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<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>CAFS</td>
<td>Centre for African Family Studies</td>
</tr>
<tr>
<td>CBD</td>
<td>Community Based Distributor</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>IPC</td>
<td>Interpersonal Communication</td>
</tr>
<tr>
<td>IUD</td>
<td>Intra-Uterine Device</td>
</tr>
<tr>
<td>KAP</td>
<td>Knowledge, Attitudes and Practices</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>VCW</td>
<td>Village Community Worker</td>
</tr>
<tr>
<td>VIDCO</td>
<td>Village Development Committee</td>
</tr>
<tr>
<td>WADCO</td>
<td>Ward Development Committee</td>
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</table>
ACKNOWLEDGEMENTS

The Zimbabwe National Family Planning Council (ZNFPC) works with a wide range of health personnel to provide family planning services. ZNFPC identified a need for these personnel to improve their knowledge of information, education and communication (IEC), to strengthen their effectiveness in promoting family planning, and this manual is the result.

Substantial inputs to the development of the manual have been made by the Ministry of Health and Child Welfare and technical and financial assistance has been provided by GTZ, which supports the Government of Zimbabwe in implementing family planning and health education activities.

The publishers would like to acknowledge the significant contribution of the many organisations and individuals who contributed in many ways, including the Communications Division of the Centre for African Studies in Nairobi; the Health Education Unit of the Zimbabwe Ministry of Health and Child Welfare; the provincial staff and personnel of the IEC, Service Delivery, Training, and Research and Evaluation Units of the Zimbabwe National Family Planning Council; and GTZ-staff, Ms. Dorothea Luke. Ms. Kathy Attawell undertook the final edit of this second, revised edition.
INTRODUCTION

In 1980, Zimbabwe adopted the Primary Health Care approach to correct imbalances in health care. Health programmes address problems identified as priorities by the Ministry of Health and Child Welfare. These priorities include HIV/AIDS, tuberculosis (TB), malaria, nutrition, diarrhoeal diseases and acute respiratory infections (ARI), reproductive health including family planning, dysentery and measles.

The purpose of information, education and communication (IEC) is to improve people’s health by increasing awareness and knowledge and changing attitudes and behaviour. The Ministry of Health and Child Welfare views IEC as a crucial component of promoting better health in Zimbabwe and developed a five year national IEC/Health Education Strategy in 1994-1995, which emphasises changing behaviour, the process of behaviour change and learning from programme activities about why people do not change their behaviour.

The Strategy aims to improve the general well-being of individuals, families and communities by encouraging people to be responsible for their own actions through their own efforts. This means using IEC to ensure that people have appropriate health knowledge and change their practices where necessary. Particular emphasis is placed on behaviours that are amenable to change through IEC/health education interventions. Examples include promoting condom use to prevent transmission of HIV and other STDs, encouraging people with TB to seek treatment, promoting effective home treatment of dehydrating diarrhoea, and encouraging families to increase the nutritional content of complementary foods for infants. IEC is also a critical aspect of programmes addressing other important health issues in Zimbabwe, such as tobacco smoking and alcohol.

This manual has been developed to support the national IEC/Health Education Strategy and is intended to guide health managers and planners in integrating IEC activities into priority health programmes. It aims to provide an introduction to the theory of IEC and a practical reference for planning and implementing IEC activities and training. The manual is divided into three sections.

Section 1 discusses the principles of information, education and communication (IEC), and includes information about the processes involved in communication and in behaviour change.

Section 2 describes the steps in planning IEC activities, and includes information about assessing the situation and collecting information, defining the target audience, designing messages, selecting communication channels and tools, and monitoring and evaluation.

Section 3 provides more detailed information about communication channels and methods, and includes information about interpersonal communication, mass communication, and different types of IEC tools.
SECTION 1 INTRODUCING IEC AND BEHAVIOUR CHANGE

CHAPTER 1 INFORMATION, EDUCATION AND COMMUNICATION

This Chapter:
- Defines health promotion, health education, IEC and communication and explains the differences between them
- Describes different models and types of communication

What are health promotion and health education?

Health promotion aims to help people to live healthy lives. It involves increasing people’s knowledge and awareness, enabling them to take action to improve their health, and ensuring that their circumstances allow them to make healthy choices. Health promotion includes:

- Health education
- Developing personal skills
- Strengthening community action
- Reorienting health services
- Building healthy public policy
- Creating supportive environments

The following Box provides some examples of health promotion activities to improve sexual health and reduce the risk of HIV and STIs:

<table>
<thead>
<tr>
<th>Health education:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increasing knowledge of the facts about HIV and AIDS</td>
</tr>
<tr>
<td>• How to care for people with HIV/AIDS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Developing personal skills:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Being able to use a condom</td>
</tr>
<tr>
<td>• Assertiveness, communication and negotiation skills for women</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strengthening community action:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Providing economic opportunities for women and young girls</td>
</tr>
<tr>
<td>• Involving churches and NGOs</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Reorienting health services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Providing HIV counselling and testing</td>
</tr>
<tr>
<td>• Integrated STD services in PHC</td>
</tr>
<tr>
<td>• Health services for young people</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Building healthy public policy:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Sex education in schools</td>
</tr>
<tr>
<td>• Legal rights for widows to property and land</td>
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</table>

<table>
<thead>
<tr>
<th>Creating supportive environments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Legal access to condoms</td>
</tr>
<tr>
<td>• Challenging harmful traditions</td>
</tr>
<tr>
<td>• Promoting condom use, abstinence and faithfulness</td>
</tr>
</tbody>
</table>

Health education is defined by the Ministry of Health and Child Welfare as "any combination of learning experiences designed to pre-dispose, enable, and reinforce voluntary adoption of behaviour..."
conducive to health”. Health education aims to increase knowledge and awareness and is an important component of health promotion.

**What is IEC?**

Information, Education and Communication (IEC) in health programmes aims to increase awareness, change attitudes and bring about a change in specific behaviours. IEC means sharing information and ideas in a way that is culturally sensitive and acceptable to the community, using appropriate channels, messages and methods. It is therefore broader than developing health education materials, because it includes the process of communication and building social networks for communicating information.

IEC interventions should involve the active participation of the target audience and adopt channels, methods and techniques that are familiar to their world view.

Information, education and communication is an important tool in health promotion for creating supportive environments and strengthening community action, in addition to playing an important role in changing behaviour.

**What is communication?**

Communication is about exchanging information, sharing ideas and knowledge. It is a two-way process in which information, thoughts, ideas, feelings or opinions are shared through words, actions or signs, in order to reach a mutual understanding. Good communication means that people are actively involved. This helps them to experience a new way of doing or thinking about things, and is sometimes called participatory learning.

All human activities involve communication, but because we take this for granted we do not always think about how we communicate with others and whether or not we do this effectively. Good communication involves understanding how people relate to each other, listening to what that have to say and learning from them. The Box below shows the differences between a communication approach, which involves “sharing information” and one which involves “giving information”.

<table>
<thead>
<tr>
<th>INFORMATION GIVING</th>
<th>INFORMATION SHARING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal teaching</td>
<td>Participatory learning</td>
</tr>
<tr>
<td>Top-down - talking at people</td>
<td>Encourages dialogue</td>
</tr>
<tr>
<td>Telling people what not to do</td>
<td>Makes an idea attractive</td>
</tr>
<tr>
<td>Professional knows best</td>
<td>Partnership</td>
</tr>
<tr>
<td>Depends on lectures and talks</td>
<td>Uses participatory methods</td>
</tr>
<tr>
<td>Educator makes decisions</td>
<td>Audience participates in deciding what is needed</td>
</tr>
<tr>
<td>Depends on posters</td>
<td>Uses many forms of visual media</td>
</tr>
<tr>
<td>Limits time for teaching</td>
<td>Makes more time if necessary</td>
</tr>
</tbody>
</table>
The effectiveness of communication depends on the characteristics of:

- the source (attitudes, knowledge, communication skills, relevance to cultural and social systems)
- the message (clear, simple, specific, factual, appropriate, timely, relevant)
- the channel used (appropriate, relevant, accessible, affordable), and
- the receiver (attitudes, perceptions, communication skills, knowledge, cultural and social systems)

**Models of communication**

Various models have been developed to help explain the process of communication, and the two described below are the:

- **S-M-C-R Model**
- **Convergence Model**

With the **S-M-C-R Model**, communication takes place when there is a Sender, a Message to be sent, a Channel for carrying the message, and a Receiver of the message. The person receiving the message must interpret the message to understand it correctly. This model assumes that the purpose of communication is to effect change in knowledge, attitude or behaviour of the "receiver". Its main weakness is that it does not allow for any real dialogue between the "sender" and the "receiver".

Unlike the S-M-C-R model, the **Convergence Model** recognises that communication involves dialogue and the exchange of information and ideas to arrive at a shared understanding. It includes the idea that individuals are active participants who bring their own experience to the process of communication, which takes place over time and consists of activities such as listening, reflection, expressing ideas and adapting feelings and behaviours. In theory, as more communication takes place, the area of mutual understanding increases.

This model illustrates several communication principles:

- People select what they see
- Interpret selectively what they see
- Choose what they remember and what they want to forget
- Words and meanings are in context and as part of relationships
- Communication is a process that occurs over time, it is not as product

**Types of communication**

There are two main types of communication relevant to IEC:

- **Interpersonal communication**
- **Mass communication**

**Interpersonal communication**, sometimes called face-to-face communication, is one of the most effective methods of communication. Interpersonal communication can be done on a one-to-one basis or with small groups, and can promote sharing of information, encourage dialogue and help people to make their own decisions.

**Mass communication** usually involves a much wider audience and employs mass media methods to reach large numbers of people at one time rather than personal interaction.

Interpersonal and mass communication play different but complementary roles in IEC. For example, a television or radio spot can introduce or make appealing a new idea or behaviour such as practising
family planning, and motivate people to visit a clinic or seek out their community health worker. Interpersonal communication can reinforce the message people have received through the mass media, provide an opportunity for them to ask questions and receive more information. In family planning, for example, interpersonal communication can also play a crucial role in determining whether or not clients use methods correctly or return for further supplies or advice. Interpersonal communication and mass communication are discussed in more detail in Chapter 5.
CHAPTER 2  CHANGING BEHAVIOUR

This Chapter:
• Explains some of the most important theories of behaviour change
• Describes the role of IEC in changing behaviour

Since one of the main purposes of IEC in health programmes is to change behaviour, it is important to understand the way in which new ideas are spread and the factors which affect the way people make decisions and adopt different behaviours. Understanding the process of behaviour change can help health planners and managers to design more effective health IEC activities.

How do new ideas spread?

Diffusion of innovation is one theory that has been used to explain the way in which new ideas are spread. Messages about an innovation - an idea, practice or product that is being introduced for the first time - for example, a new family planning method, improved weaning food recipe or use of condoms to protect against STIs, are diffused - or spread - to an audience using various communication channels.

Whether or not people take up or adopt a new idea, product or behaviour, depends on the characteristics of the innovation itself and of the audience being targeted.

The innovation

An innovation is more likely to be adopted, and to be adopted more quickly, if it is:
• Seen to have advantages in terms of social prestige, convenience, satisfaction or economics
• Perceived to be compatible and consistent with needs, existing values and past experience
• Simple to take up and does not require people to develop new skills and understanding. The more complicated or difficult a new idea is to understand, the less likely it is to be adopted
• Easily tried out and experimented with
• Visible, meaning that the results of using it can be seen easily by others in a community

The target audience

Different individuals take different periods of time to adopt new ideas and practices. One way to look at this is to categorise people according to how long it takes them to adopt an innovation. Using this approach, individuals are categorised as:
• Innovators
• Early adopters
• Early majority
• Late majority
• Laggards

The role and characteristics of these different categories of adopters are described in the box below.
<table>
<thead>
<tr>
<th>ADOPTER CATEGORY</th>
<th>ROLE AND CHARACTERISTICS</th>
</tr>
</thead>
</table>
| Innovators       | o Play an important role in bringing ideas from outside into the community  
|                  | o First to adopt a new idea  
|                  | o Active information seekers  
|                  | o Willing to take risks, adventurous  
|                  | o Able to cope with uncertainty and to accept occasional setbacks  
|                  | o Not always respected by other members of the community and should therefore not be used as role models for others  
|                  | o Require little time to be motivated  
| Early adopters   | o Decrease uncertainty about a new idea by adopting it and giving testimony to others  
|                  | o Usually respected by their peers and can serve as examples to the rest of the community  
|                  | o Should be consulted before adopting new ideas  
|                  | o Able to motivate others formally or informally and should be involved in community mobilisation around new ideas  
| Early majority   | o Average members of the community  
|                  | o Frequently interact with their peers  
|                  | o Seldom hold leadership positions  
|                  | o Think for some time before adopting a new idea and take more time to convince  
| Late majority    | o Sceptical about new ideas  
|                  | o Adopt new ideas after the average member of the community and after most others have done so  
|                  | o Adopt new ideas because of peer pressure or economic necessity  
| Laggards         | o Last to adopt an innovation  
|                  | o Very traditional in outlook and base decisions on what has happened in the past  
|                  | o Outside the community "mainstream" and interact with others who are also traditional in outlook  
|                  | o Change behaviour a long time after changes in their awareness and knowledge  
|                  | o Suspicious of innovators and agents of change and take more time to convince  
|                  | o Often poor economic position makes them very cautious  |
How do people change their behaviour?

People go through different stages in the process of behaviour change, starting from being unaware of an issue, to concern, to seeking knowledge and skills, to adopting a different behaviour, and finally reaching a maintenance stage. These stages have also been described as the innovation decision-making process:

- Knowledge
- Persuasion
- Decision
- Implementation
- Confirmation

At the knowledge stage, the intended audience is exposed to information about the desired behaviour change, is attracted to the message and pays attention to it, understands the message and what the new behaviour involves. The audience has to be persuaded or convinced that the new behaviour is relevant to them. Having understood the message, the audience must develop a positive attitude towards the desired behaviour and remember what they need to do and when they need to do it, before they will be motivated to put the new behaviour into practice. Once they are motivated, people will decide to adopt the behaviour and implement their decision by putting the behaviour change into practice. At the maintenance or confirmation stage, people who have tried the behaviour once continue to practise it regularly.

These are not equal stages and people often take a long time to change their behaviour. They will rarely adopt a new behaviour after just hearing about it. For example, people may acquire knowledge quickly about a new concept such as family planning but take some time before they make a decision to practise family planning themselves. The Box below provides an example of the stages people may be at in the process of changing their behaviour to adopt family planning. The same approach can be used to analyse what stage people have reached in adopting other behaviours, such as condom use, measles immunisation or tuberculosis treatment.

- Those who are unaware of family planning
- Those who have heard about family planning but need more information
- Those who are informed but need to be persuaded and convinced of the benefits of family planning
- Those who are persuaded but who are yet to decide whether they really need family planning
- Those who have decided but have yet to take action to implement their decision
- Those who have taken action but who need to confirm that their choice was a good one
- Those who have confirmed but need to be encouraged to maintain the family planning practice they have chosen
Theories about behaviour change

There are many theories which attempt to explain the process of behaviour change. All of them have their strengths and weaknesses. These theories should be used as "tools" to help us think about how and why people change their behaviour and what type of IEC approaches and activities might best achieve our objectives. The main theories about behaviour change are the:

- Health Belief Model
- Social Learning Theory
- Cognitive Behaviour Theory
- PEN Model

The Health Belief Model assumes that people change their behaviour according to whether or not they believe themselves to be at risk. For example, in order to use condoms an individual must believe that he or she is at risk of HIV, feel that HIV is serious, and believe that HIV transmission can be prevented by using condoms. One of the weaknesses of this model is that individual activities are directed towards the individual, but do not take account of an individual's context and the social, cultural and economic factors which affect their behaviour. For example, a woman may believe herself to be at risk of HIV, but may not be in a position to negotiate condom use with her sexual partner.

In contrast, Social Learning Theory assumes that behaviour change is the result of interaction between personal factors (knowledge, skills, self efficacy, self control) and environmental influences (family and social support and expectations). Using this model, IEC activities would include building social support for behaviour change, in addition to targeting individual beliefs.

Cognitive Behaviour Theory assumes that people need skills as well as information. IEC activities based on this theory emphasise educational interventions which include activities to personalise information, training in decision-making and assertiveness, and practice in applying these skills.

The PEN-3 Model is based on the idea that health education is a dynamic process involving the individual, family and community, and behaviours are divided into positive or beneficial, exotic and negative. Negative behaviours are identified as appropriate targets for change.

All these theories assume that people will be motivated to change their behaviour if they are aware of the long term risks. But behaviour change is not always the result of rational decisions and people often have other more immediate priorities and concerns or less control over their lives and environment than is required for rational decision-making.
This simple framework has been developed to help understand behaviour change in relation to HIV/AIDS, but could be adapted for other health issues. The framework suggests that HIV/AIDS behaviour change depends on:

- **The RATIONAL element based on knowledge**: people need to know about a disease or illness, how it is and is not transmitted, how likely they are to be infected, and what they can do to avoid infection.

- **The EMOTIONAL element based on intensity of attitudes and feelings**: people need to feel an intense and personal vulnerability to a disease, an emotional commitment to the behaviour needed to avoid it, a compassion for those already affected, and a concern to protect others they love from becoming infected. Emotions may be positive, based on love or hope for reward, or negative, based on fear or anger.

- **The PRACTICAL element based on personal skills**: people need to be competent and confident in practising the new behaviour, whether it is use of condoms or changes in sexual practices.

- **The INTERPERSONAL element based on social networks**: people need to associate with and be supported by others, their family, peer groups, villages and neighbourhoods, workers' associations, to reinforce the knowledge, attitudes and skills needed for behaviour change.

- **The STRUCTURAL element based on the social, economic and cultural context in which behaviour takes place**: people need to have access to the necessary supplies and services (such as condoms and blood testing) and to live in an environment where safer sexual behaviour is made possible while risky behaviour is made difficult.

Factors affecting behaviour change

Whether or not people change their behaviour is influenced by many factors, including:

- What they know or do not know (knowledge)
- What they think or feel and what they feel able to do (beliefs, attitudes and self-esteem)
- What they know how to do (skills)
- How other people in the community behave, think and feel (peer pressure and social influences)
- The wider environment (culture, religion, economic factors, health policies, legislation and service provision)

People are therefore more likely to change their behaviour if:

- They know what the behaviour is and how to perform it
- They can learn from experience or through observation that with certain behaviour certain results are achieved
- There is something about the behaviour or an external factor that motivates them to perform the behaviour
- They feel they are in control of the behaviour and have the relevant skills
- They observe the behaviour being practised by people they consider to be role models
- The behaviour is reinforced and encouraged
What is the role of IEC in behaviour change?

Understanding something about the process of behaviour change and the factors which affect it can help to define where IEC can play a role.

At the individual level, IEC activities can provide people with the opportunity to develop their personal knowledge, skills and confidence and to reconsider their attitudes, beliefs and behaviour. It can increase awareness, provide information, persuade and motivate people to change behaviour, and provide reinforcement to confirm and sustain behaviour change. In the case of HIV and AIDS for example, IEC can provide opportunities for people to:

- Learn about HIV and STD transmission, reproduction, contraception and relationships
- Accept that they themselves are vulnerable to HIV/STDs or may be a risk to others
- Learn the relevant skills, to help them in effective communication, assertiveness and condom use
- Have confidence and belief in their ability to reduce their risk
- Understand how they are influenced by other people and their environment and feel able to act differently

At the wider community level, IEC can encourage local organisations, decision-makers, the media and other influencers to change social attitudes and norms and the wider environment which influences people’s behaviour. In the case of HIV/AIDS, for example, IEC can:

- Encourage shifts in social and cultural influences or pressures, for example that give women little say about when and how they have sex
- Overcome barriers such as restrictive policies or legislation, poor health services, stigmatisation or discrimination, for example laws that criminalise prostitution which make it difficult for sex workers to access information, or that prevent unmarried people from obtaining condoms, or reluctance to use STD services because of associated stigmatisation
- Ensure that policy makers receive up to date information for appropriate policy making
- Sensitise school administrators, traditional healers, leaders, convince religious and community leaders
- Sensitise broadcasters, journalists and others who work in the media
- Reorient health professionals, health educators and relevant personnel in other sectors

The Box below provides examples of the role that IEC can play in promoting behaviour change in HIV/AIDS programmes and in family planning programmes.
**THE ROLE OF IEC IN HIV/AIDS PROGRAMMES**

1. *Sharing information* - Ensuring that communities have information to understand the relationship between sexual behaviour and HIV and STI transmission, about seeking care, about protecting themselves and taking preventive measures.

2. *Advocacy* - Encouraging discussion of social, economic and organisational factors which are barriers to behaviour change and good health.

3. *Promoting services and products* - Advertising and promoting services such as counselling, STI treatment, condom provision, and promoting products such as condoms.

4. *Building public opinion* - Changing public opinion, for example, attitudes towards people with HIV and combating stigma and discrimination, and encouraging resource allocation for treatment of people with HIV/AIDS.

5. *Shaping attitudes* - Shaping the attitudes and behaviour of future generations through targeting schoolchildren and young people.

**THE ROLE OF IEC IN FAMILY PLANNING PROGRAMMES**

1. *Informing* - Informing the target audience about why family planning is important and about methods of contraception.

2. *Persuading* - Persuading people of the personal benefits of family planning.

3. *Motivating* - Motivating the target audience to make informed choices about and to use family planning.

4. *Encouraging* - Encouraging those who have been persuaded and motivated to adopt family planning to inform, persuade and motivate others to do the same.
SECTION 2 PLANNING IEC ACTIVITIES

Many IEC programmes and activities have failed to achieve their expected or intended impact on behaviour. Lessons learned from past experience show that the following components are common to effective IEC programmes, and planning should take these into account:

Good background research

Effective interventions are based on accurate information about knowledge, attitudes, beliefs, behaviours, and about social and community networks and norms.

Setting realistic objectives

Objectives should be realistic, measurable and specific, and there should be a clear time frame for achieving them. Objectives for changing knowledge and attitudes can usually be more ambitious than those for changing behaviour. Behaviour change objectives need to bear in mind the context, services available, resources, norms and enabling factors.

Participation of the target audience

IEC is more likely to achieve its objectives if the target audience participates in planning, implementing, monitoring and evaluating activities and, as a result, more culturally sensitive and appropriate approaches are used. A participatory approach should be used in the design and development of messages and in the choice of media.

Advocacy for change

Successful IEC combines activities targeted at changing behaviour with advocacy to change attitudes and the social environment, for example seeking the support of community and opinion leaders for changing the social factors that contribute to problems or prevent people changing to more healthy behaviours.

Multiple approaches

The wider the range of approaches used, the greater the chances of reaching the broadest range of people. For example, using radio, printed materials and drama makes it possible to reach urban and rural, and literate and less literate audiences. Mass media can be useful in raising public awareness but is less successful in changing behaviour. The most successful IEC uses a mix of mass media and interpersonal communication backed up by appropriate services. For example, mass media campaigns raising awareness about HIV can be backed up with telephone hotlines or access to individual counselling services to enable people to receive more detailed information, and a mass media campaign backed up by social marketing with the provision of condoms may be the most effective way to increase condom use. It cannot be assumed that mass media campaigns will reach people everywhere, especially those in rural areas with limited access to communications media or those with low literacy levels.

Effective monitoring and evaluation

IEC has often been given low priority because it is not well monitored or evaluated and this makes it difficult to assess its usefulness and impact. However, it is possible to monitor and evaluate IEC activities if this is planned from the beginning and practical, measurable indicators are developed.
which provide the information required to judge success. Monitoring and evaluation which provides
feedback should be a key element of IEC programmes.

Integration into programmes and linkage with services

Too often, IEC is a added on to a programme as an afterthought rather than being considered at the
planning stage. IEC activities should be as well planned as “technical” components of a programme,
using expertise in communication, advertising and marketing, and linked to services and other
programme components from the start. Adequate resources should be allocated as part of an overall
programme budget. IEC is most effective when it is combined with and backed up by relevant
services and when, for example, messages are linked to measures that support behaviour change. For
example, ensure that people have access to condoms, to DOTS for TB or to family planning
services, or are able to purchase impregnated nets if these are being promoted to prevent malaria. In
the case of HIV/AIDS/STI, for example, an integrated approach would include interpersonal
communication and counselling, provision of effective STD services and of condoms, and linkages
with other services to support healthy sexual behaviours. IEC alone cannot achieve behaviour
change.

Enlisting support

It is important to ensure that political, social and religious leaders are involved as early as possible,
to create a favourable climate for messages about behaviour change.

Sustainability

It is important to ensure the sustainability of messages and campaigns. Campaigns that are ad hoc,
lack continuity and unconnected are less effective. Sustained activities help to keep issues on the
agenda and in people’s minds.

For IEC to be successful, careful planning following these steps is essential:

ASSESSING THE SITUATION:
• Find out about the audience
• Find out about policies, programmes and available resources
• Identify needs and priorities

DESIGN:
• Decide on objectives based on the identified problems to meet the needs of the target
  audience
• Design, pre-test and revise messages
• Select appropriate communication channels and media
• Mobilise resources
• Draw up an action plan

How to assess the situation is discussed in more detail in Chapter 3, and steps in designing an IEC
strategy in Chapter 4.
CHAPTER 3        ASSESSING THE SITUATION

This Chapter:
• Explains what information needs to be collected about the community and how to collect and analyse this information
• Discusses assessing available resources
• Describes how to use information to decide about IEC priorities

Find out about the community

The first step in IEC planning is collecting and analysing information about the audience, their social settings, characteristics and factors affecting behaviours. It is important to find out as much as possible about the potential target audience through a process of community diagnosis and analysis, where health workers and planners work together with communities to examine their situation, assess health problems and information needs, and identify solutions. The effectiveness of communication and the relevance of messages depend on knowing and understanding the audience, in particular, their concerns, what they know and understand, and their beliefs and attitudes.

Characteristics of the audience such as their age, sex, income and literacy level, will determine what messages and methods will be most appropriate. It is also important to assess the characteristics of the community in relation to the issues discussed in Chapter 2, for example what adopter category they might fit into and where they are in the behaviour change decision-making process.

Not everyone is equally open to new ideas and different population groups vary in their knowledge and attitudes about innovations and in the access they have to communication channels. IEC strategies need to be designed for the particular circumstances of the intended audience using appropriate messages, materials and communication channels.

For example, mass media may be the most appropriate IEC approach when people are at the unaware stage, but interpersonal communication may be better suited to the adoption and maintenance stages. Innovators and early adopters tend to be urban-based, better educated, have higher incomes and greater access to mass media channels such as television and radio. But the majority of people in Zimbabwe live in rural areas where mass media may be less accessible than other channels of communication.

What information needs to be collected?

Depending on the focus of IEC activities you may need to find out about the following:

Demographic factors
• Size of the catchment area
• Population distribution and density
• Vital statistics
• Number of children under five in each household
• Number of women aged between 16 and 49 in each household
• Average family size
• Literacy, age and gender

Socio-economic, environmental and cultural influences on health and behaviour
• Occupation, for example, agriculture, mining, other income-generating activities
• Environmental factors, for example water, sanitation, housing
• Lifestyles, for example sexual behaviour, use of alcohol, smoking
• Culture, religion, language and beliefs

Health, social and health services issues
• Disease distribution and trends
• Nutritional status, infant feeding and weaning practices
• Social problems such as teenage pregnancy, unemployment, divorce
• Availability and use of health services, including hospitals and clinics, and traditional healers
• Community perceptions about health services
• Attitudes of health providers
• Existing health education activities

Factors influencing health behaviours
• Knowledge
• Attitudes
• Beliefs
• Practices
• Norms

Community structures and institutions
• Community leaders, influencers and opinion leaders
• Schools, churches and other organisations
• Women's groups and other community and social associations

Communications infrastructure
• How information is received, for example through political structures such as VIDCOs and WADCOs
• How information and knowledge are shared, for example at meetings, rallies
• Communications technology, for example, radio, television, video, films
• Access to printed media, for example, newspapers, books
• Differences in access to communication channels and medias between different groups and areas of the country
• Informal communications networks and social networks

FINDING OUT ABOUT FAMILY PLANNING KNOWLEDGE, ATTITUDES AND PRACTICES

• What is the desired family size? What is the actual family size?
• Do people have a preference for male children?
• What is the age at marriage?
• Have members of the community heard about family planning?
• Where did they hear about it? From whom would they prefer to hear about it?
• What do people think and feel about family planning?
• Do people practice family planning? If not, why is this?
• What methods of family planning do people use?
• Why do people stop using family planning?

Methods of collecting information

Depending on the type of information to be collected, the following methods can be used:
• Talking to the community, including community and opinion leaders, using methods such as
focus group discussions and interviews
- Listening and observing in the community
- Talking to health workers and traditional healers
- Reviewing records and epidemiological data from clinics and other health service sources
- Studying maps, reports, census figures and survey data
- Knowledge, Attitude and Practice (KAP) studies

All these methods have their strengths and weaknesses, and their usefulness depends on the type of information required. Records and clinic data may be the best sources of information about demographic factors or about the population groups that are most affected by particular health problems. KAP studies produce useful data about what people say they know, think and do. But to find out what people actually think and do is best done through methods such as focus groups, and observation can provide useful information about the social and cultural factors that influence behaviour.

The examples in the Boxes below illustrate how different methods can be useful for obtaining different types of information. The first shows how focus groups revealed valuable information about people’s attitudes towards condom use, which was used to design appropriate IEC messages and strategies. The second provides examples of how listening surveys can be used to find out about people’s beliefs and concerns.

### FINDING OUT WHAT PEOPLE THINK ABOUT USING CONDOMS

Before developing IEC activities and messages to promote condom use in Zimbabwe, focus groups were held with men, women and adolescents in rural and urban settings to discuss what motivates them to purchase and use condoms and what prevents them from doing so.

The discussions revealed that people associate condoms with promiscuity, prostitution and casual relationships, that a partner found with condoms would be considered to be unfaithful, that people judged whether or not someone was likely to have HIV on perceptions of their lifestyle, that many men do not believe that condoms protect against HIV transmission and older men are less likely to use condoms.

Reasons given for not using condoms included the need to show trust in your partner, women's lack of authority over men, fatalism, young girls are considered to be at low risk, and condom use is not pleasurable for men.

All of these factors have important implications for IEC, in terms of different messages for different target audiences. As a result condom marketing was designed to target men, and messages were developed to emphasise trust associated with consistent condom use and to promote condoms as pleasurable, reliable and strong.
LISTENING SURVEYS

Listening surveys help to find out people’s views and attitudes. They can provide ideas for developing educational materials and messages. A second listening survey later on can be used for evaluation, to see whether people are saying different things following IEC activities.

To carry out a listening survey requires spending at least a day in the community, or longer if you do not know very much about the community or they are wary of outsiders. Carrying out a listening survey involves spending time in public places where people meet and talk, on the bus, in market places, bars, hospital waiting areas, pharmacies, hairdressers and shops. Start a conversation with people about the subject you are interested in finding out about and listen to what they say. Try not to interrupt or correct them - the object of the exercise is to find out what people think, and to identify the main issues and problems.

EXAMPLE A: A listening survey in a rural village showed that men and women of all ages were very concerned about the drought in the area and the shortage of food and other resources. People were also talking about the difficulties of looking after sick people at home, although AIDS was not mentioned specifically as a possible cause of sickness. This information enabled IEC activities to be designed to help people to acknowledge the problem of AIDS and provide training and support for home-based care.

EXAMPLE B: A listening survey among 16-17 year olds in a secondary school revealed that they were very worried about their exams, future careers, lack of money and anxious about their friend's opinions of them, and about whether they had sex or were in sexual relationships. Sexual pressure from older men was a particular concern for girls. The findings enabled an IEC programme to be developed that provided information about reproduction, contraception and sexuality as well as HIV prevention, and that helped these teenagers to develop the skills to refuse sex and take more responsibility in their relationships.

HOW TO CONDUCT A FOCUS GROUP DISCUSSION

The person facilitating the discussion does not participate in the discussion: their role is to introduce the group members, introduce the topic, ask key questions and record the main points.

1. Select a group of 8-10 people who share similar backgrounds, ages and experiences. People will talk more freely if they have a lot in common.
2. Arrange a comfortable meeting place where people can sit in a circle; consult the group about the time and place.
3. Prepare a topic guide as a reminder of the main issues to be discussed.
4. Explain the aim of the discussion and assure the participants that their role is valued and important.
5. Use the topic guide to focus the discussion. Try not to ask personal questions, instead ask what friends or others in the community do.
6. Encourage group members to respond to questions and to talk as openly as possible. Try to ensure that everyone is given an opportunity to speak. Don’t become involved in the discussion except to remind people of the questions.
7. Summarise the discussion at the end but without giving an opinion or making judgements.
8. Ask the group for their suggestions about IEC activities and ways of solving particular problems.

Analysis of community information
Analysis is about interpreting information, thinking about what it tells us and how we can use what we have found out to plan IEC activities. Analysing and interpreting data collected from the community should tell you about the target audience, their health problems and behaviours, factors which influence health behaviours, IEC needs, and the differences in all these factors between different population sub-groups.

The information collected should provide an understanding of the factors that influence people’s behaviour. These include:

- Knowledge and beliefs (what they know and believe)
- Values (what they feel is important in their lives)
- Attitudes (negative and positive feelings)
- Skills (what they know how to do)
- Self-esteem (what they feel about themselves)
- Self-efficacy (their confidence and ability to make changes in their lives)
- Peer pressure and social influences (of family, friends and other people in the community)
- The environment in which they live (cultural or religious views, income, health services).

People’s age and sex also affect what they do. For example, men and women are expected to act in different ways when it comes to sexual behaviour, and their behaviour is affected by what is widely considered to be appropriate. It is particularly important to understand social networks and the context within which people operate, in order to target IEC interventions effectively. For example, the behaviour of commercial sex workers is influenced by the attitudes and practices of their clients, and IEC needs to target clients of sex workers as well as the sex workers themselves.

More specifically, analysis of community information should identify gaps in people’s knowledge and skills, priority health problems and the extent to which these are because of inadequate knowledge, incorrect beliefs or behaviours that could be addressed by IEC interventions. At the individual level, people need the opportunity to build on their personal knowledge, skills and confidence, and to reconsider their attitudes and beliefs. And, because their behaviour is affected by their wider environment, IEC activities need to work with local organisations, decision-makers and the media to encourage changes in social attitudes.

Careful analysis of information collected is therefore the basis for planning IEC strategies, messages and methods which are most likely to bring about desired behaviour change.

ANALYSING INFORMATION ABOUT HIV/AIDS

HIV/AIDS data in Zimbabwe shows that there are high rates of infection in young women, in urban centres and along trade routes, and that the most vulnerable populations are the military, sex workers, seasonal farm labourers. What does this information mean in terms of developing an IEC strategy?
SUMMARY OF USES OF COMMUNITY INFORMATION

Information collected from the community can be used for:

- Identifying health and social problems
- Identifying information needs, and behaviour change priorities
- Developing IEC objectives
- Developing IEC strategies
- Categorising the target audience
- Identifying the communication channels through which people usually or traditionally receive information
- Deciding which communication channels are appropriate for identified target groups
- Providing baseline information against which to evaluate change

Find out about policies, programmes and available resources

Analysis of programmes and policies can help to provide information about what services are available and where these are available. Existing polices and programmes determine what types of materials are permissible and in circulation already.

National policy should guide IEC planning and implementation. For example, national HIV/AIDS policy in Zimbabwe emphasises:

- Providing families, schools and churches with relevant information and support to develop communication skills to discuss HIV/AIDS/STI issues
- Developing materials that take account of the context of stigma, fear and discrimination
- Developing materials using participatory methods
- Developing appropriate and effective messages based on the perceptions and understanding of different population groups
- Monitoring and evaluating IEC activities

You can also learn from the past experience of other programmes about appropriate IEC strategies, media and approaches, and about what has worked and what has worked less well with different target groups and why. For example, non-government organisations, women’s groups and other institutions may have tried different approaches with different target groups, including outreach activities, community mobilisation, materials development or advocacy and it may be useful to find out about and build on the lessons learned from their experience.

Lessons learned from previous HIV/AIDS IEC campaigns and programmes include:

- Failure to pre-test messages properly has led to their rejection as unacceptable or withdrawal as the messages have been heavily criticised
- Campaigns have tended to be too general in nature and have not always evolved in response to changes in the AIDS epidemic, or have used global themes without adaptation to local circumstances
- Over-emphasis on print materials and mass media such as television has resulted in failure to reach rural or less literate populations and fails to engage people in a dialogue
- Creation of demand without ensuring that this demand can be met
- Failure to complement mass approaches or distribution of printed materials with interpersonal approaches
- Failure to engage community leaders or potential opponents in the development of IEC campaigns
- Focusing campaigns on target groups in a way that stigmatises them or makes others less
• Concerned, instead of directed different messages at different audience segments
• Over-emphasis on creating awareness and knowledge without following up with appropriate strategies to change attitudes or increase skills in order to enable people to change their behaviours
• Failure to utilise a range of channels to reach people where they are rather than where it is convenient for the health services

Before deciding on the approach and content of an IEC strategy it is also important to assess what resources are available to carry out activities. This includes assessing:

Financial resources - for example, funds available for training in communication skills, production of health educational materials, commissioning media and social marketing organisations

People and organisational resources - for example, other health programmes, health and extension workers who are trained in IEC, community and voluntary organisations and NGOs, church groups, formal and informal community leaders, to assess what institutional capacity exists and which agencies, public and private, have the capacity to carry out or support IEC activities. Find out about institutions, organisations and individuals that can help to develop materials, if you do not have in-house capability. These might include advertising agencies, film companies, resource centres, artists and designers, printers, journalists, musicians and broadcasters

Material resources - for example, equipment, media available, health education materials, radio spots provided free of charge, transport. Find out what materials already exist and assess their suitability in terms of content and design for the target groups that have been identified. It can be helpful to carry out a media assessment to determine what media are currently available and are being used, and how useful they have been.

Communications resources – for example, what media are available and how appropriate these are, and informal social and communication networks
It can be helpful to consider possibilities for sharing resources and activities with other programmes, to avoid duplication and overlap and to maximise the use of existing resources. For example, can health personnel working in a number of different programmes be trained in communication skills at the same workshop?
Finally, you need to consider what resources are available to people to enable them to change their behaviour and to support behaviour change. This is an important aspect of the process of helping the community to assess their problems and priorities and to identify solutions.

Identify needs and priorities

Community analysis and diagnosis should provide information about gaps in knowledge, attitudes and practices and areas where behaviour change is a priority and, most important, what can be modified by IEC interventions. This provides the basis for deciding on areas for the focus on key messages.

Analysis of the information collected from audience analysis might tell you, for example, that people have misconceptions about family planning methods, lack information about preparation of nutritious meals for infants and young children, or are unaware of antenatal services available or of the importance of completing their TB treatment. The following examples suggest some problems and possible IEC responses:

• Family planning – problems include continued high population growth and high rates of
teenage pregnancy, and community diagnosis shows that people are unaware of family planning or have misconceptions about family planning methods – IEC needs to increase awareness and encourage increased uptake of family planning

- HIV/AIDS/STIs – problems include high rates of transmission of HIV and STIs, and community diagnosis shows that condom use is low, and that there are high levels of discrimination and fear about HIV/AIDS – IEC needs to promote safer sex messages including the use of condoms, as well as to change discriminatory attitudes towards people with HIV

- Infant nutrition – problems include malnutrition and community diagnosis shows that infants are given complementary foods such as watery gruels and porridges containing inadequate nutrients and that may also be contaminated through the addition of water that has not been boiled - IEC needs to promote adequate and hygienic complementary feeding

- Dysentery – problems identified include a high rate of young child mortality from dysentery – IEC needs to encourage preventive behaviours such as hand-washing with soap and making sure water is boiled

- Malaria – problems identified include high malaria incidence and high rates of death and illness among young children and pregnant women, and community diagnosis shows that these are caused, in part, by lack of awareness and incorrect beliefs about the significance and causes of malaria and how to prevent and treat it – IEC needs to get across the facts about malaria, encourage people to seek treatment earlier, to use repellent soap, insecticide impregnated nets and other measures to avoid mosquito bites

It is important that people are enabled to identify their own priorities and to identify solutions. IEC programmes cannot do this for people, they can only work with them to help with the process. IEC cannot provide all the answers, and needs to be supported by other initiatives to meet people’s needs. Health concerns may be less of a priority for communities than other issues such as water, food, schooling for their children. Community participation is therefore a crucial aspect of identifying problems and solutions.

A participatory approach, which actively involves people in discussions and practical activities, facilitates good communication, enables people to think more deeply about their problems and to develop solutions themselves. Participatory methods which can facilitate the process of identifying problems and problem solving include brainstorming, discussion pairs and small group work focusing on a problem solving exercise, a decision-making task, writing letters to a problem page as the starting point for a discussion, role play, drama, poetry, songs, stories and fables, pictures and photographs, flip charts, and videos.
CHAPTER 4    DESIGNING AN IEC STRATEGY

This Chapter describes the steps in designing an IEC strategy, after you have carried out the community assessment and analysis, which are:

- Decide on objectives
- Define the audience
- Design, pre-test and revise messages
- Select media, communication channels and tools
- Mobilise resources
- Draw up an action plan

From the community diagnosis and analysis and assessment of existing programmes you should already have a clear idea about the health problems and audience that your IEC strategy will address. Developing a strategy requires looking at these in more detail.

**Decide on objectives**

An objective is what you want to see changed or achieved at the end of an activity or programme.

IEC objectives should be based on the problems you have identified and meet the needs of the target audience. The objectives should be:

- Specific – clear about what is to be achieved
- Realistic – possible given the extent of the problem, context and the available resources
- Measurable – outcomes or changes that can be measured
- Relevant – contribute to addressing the problem
- Prioritised – the most important – as a general rule try not to have more than three main messages for each priority area – too many messages may confuse or not be remembered

Assessing whether or not objectives have been achieved will form the basis for evaluation. Clear objectives also help to make decisions about implementation such as what type and number of activities, staff required, what activities should come first. Once you have clear objectives you can decide what activities are needed to achieve them.

An objective for IEC should specify:

- The intended change in a measurable form, for example increase in knowledge, increase in condom distribution, uptake in family planning services
- The amount of change relative to the current situation, for example percentage of people using condoms, number of schools with sex education programmes
- The target group for the intended change, for example schoolchildren, or sex workers, or women aged 15-49 years
- The time period over which the intended change should take place, for example over the next two years

**Define the audience**

Using the community analysis, you need to consider in more detail who the target audience or audiences are and their characteristics. Audience analysis requires three steps:

**Segmenting**

Decide who is their target audience and consider their demographic, social, cultural and other
characteristics. Are they women, men, young people or elderly, urban or rural dwellers, community and social leaders? Dividing a population into sub-groups helps to identify groups which lack information or which have particular needs, as well as to consider the most effective communication channels to reach them. For example marginalised groups may have different needs and be harder to reach than other population groups, women may have lower literacy levels than men, and rural populations less education than those in urban areas.

The main purpose of segmenting is to create smaller groups which share similar characteristics, so that targeting can be more effective, and also because IEC can create positive peer pressure for change within a particular group. Audience segmentation improves the likelihood that an appropriate message will reach the intended audience.

It is not helpful to talk in terms of high risk groups, because this means others who do not belong to a particular group may not consider themselves to be at risk of the particular disease and also because it can lead to discrimination and stigmatisation of particular groups in society. For example condom use has been associated with commercial sex workers who were categorised as a high risk group, making it more difficult to promote the use of condoms in other sexual relationships.

Targeting

Targeting means identifying the needs of each segment or sub-group, and selecting one or more target groups at which to direct a campaign which is tailor-made for each group. Separate IEC activities can be targeted at, for example, national elites and health professionals, community opinion leaders, population groups that have been identified as likely adopters of the behaviour change being promoted, or those who have yet to adopt new behaviours.

It can also be helpful to define target groups as primary and secondary target groups:

- The primary target group refers to those groups of people whose behaviour is the focus of change, for example women, mothers of young children, men.
- The secondary target group refers to those groups of people who influence the decisions and behaviour of the primary target group, for example husbands, community leaders, mothers-in-law.

Positioning

It is important to establish credibility among the intended target groups. Credibility is the degree to which a source of channel of information is considered to be knowledgeable and trustworthy. Peers are usually considered to be more trustworthy, but health professionals to be more knowledgeable. However, professionals and experts may be socially distant from the target audience.

Design, pre-test and revise messages

A message is a specific piece of information that you want to put across to an individual or community, with the intention of changing behaviour. Messages are central to the communication process. Messages and the way they are presented are crucial to moving individuals from the unaware stage to the adoption and maintenance of behaviour stages. Messages are developed to meet the specific information needs of an audience, based on their concerns and level of knowledge, or to create demand. Development of messages should be guided by the analysis of the audience, the problem and the resources available.

Messages should be:
• Accurate
• Focus on a few key points
• Specific
• Clear
• Use uncomplicated language
• Simple to understand
• Relevant
• Culturally appropriate and acceptable
• Emphasise options, practical actions and solutions that are possible

Messages should include information that will improve the knowledge and skills of the target group, and about preventive measures and where to obtain more information from. Developing messages involves deciding what approach to take and deciding on message content.

Decide about approach

Messages can take one of several approaches, depending on what IEC is trying to achieve. It is important to remember that people respond to messages differently and that what might persuade one person may not appeal to another.

Informative

The message creates awareness about a new idea and makes it familiar to people. Mass media is mostly used for wide coverage and reaching a large audience. Print materials and interpersonal communication are used to reinforce mass media messages and inform people in more detail.

Educating

The new idea is explained including its strengths and weaknesses. This approach is used when people are already aware but need more information or clarification. Interpersonal communication with individuals or small groups is probably the most appropriate way to provide more detailed information, and can be reinforced by print material such as books, pamphlets and other multi-media approaches such as films, slide shows and videos.

Persuasive

The message promotes a positive change in behaviour and attitudes which encourages the audience to accept the new idea. This approach to message development involves finding out what most appeals to a particular audience. Persuasive approaches are more effective than coercive approaches in achieving behaviour change. Interpersonal communication is the most effective way to get across persuasive messages. Other persuasive methods include radio spots, advertisements and posters.

Prompting

Messages are designed so that they are not easily ignored or forgotten, or to remind the audience about something and reinforce earlier messages.

Entertaining

The attention of the audience is drawn to the new idea by using messages which entertain, for example, posters, songs, humour, puppets or film.
Decide about content

Once the general approach has been selected, the next step is to consider exactly what the message will say and how it will say it. What type of appeal will be used? It can be:

Emotional or rational

Most messages either appeal to people's emotions or provide rational reasons why they should or should not do something. Emotional appeals stimulate basic human emotions, such as love, fear, hate, anxiety, security. Rational appeals make the case for doing something using logical arguments and supporting evidence.

Emotional appeals are better at attracting attention to the message and provide an incentive to read or listen to it. Any appeal which involves the audience emotionally is likely to be better remembered than a non-emotional one. However, messages which create a lot of fear do not bring about permanent behaviour change. Those who may be at risk will reject the message and those who are not at risk become unnecessarily anxious and worried, so messages based on fear should be avoided. Moral messages and those which blame others are also not particularly effective, as they may deter people you want to reach or allow people to think that the problem does not concern them. Rational appeals are usually more convincing.

A combination of emotional and rational appeal, which gets people's attention, convinces and promotes action is usually most effective.

Positive or negative

Negative or threatening messages are a form of emotional appeal. These can include messages which suggest that unfavourable consequences will occur if the receiver of the message does not follow the course of action recommended.

It is important to be careful if negative appeals are used. People may view the message as unlikely or improbable "that won't happen to me or my family" or as not of immediate concern "it might happen sometime but there is no need to worry about it now" or as not very significant "if it happens it won't make much difference". People tend to ignore potential threats or negative appeals for as long as possible and it takes a lot of convincing evidence before people take threats seriously. Most people regard themselves as being personally exempt from danger. In general, more positive appeals are more effective, especially those which provide people with options, because they make people feel that they are in control and able to make choices.

Mass or individual appeals

A commonly used form of appeal is the mass appeal "Everyone is doing it so why don't you too". Social pressure can result in an individual adopting a behaviour even if they are not convinced about the reasons why they should.

The individual appeal should be used for issues where social pressure and approval are not so important. Even though these messages are designed to appeal to individuals they do not necessarily have to go through individual channels.

Humorous or serious appeals
Humour can increase the effectiveness of communication if it helps to gain attention and the use of humour is consistent with the basic message. When used creatively, humour can help to communicate messages about issues, products or services that are not easy to discuss, such as personal or domestic hygiene or sexual behaviour. However, humour needs to be used carefully, to make sure it is acceptable to groups or communities and does not offend people.

One-sided or two-sided arguments

The effectiveness of one-sided or two-sided arguments depends on the target audience. One-sided arguments tend to be more effective with target groups which are already favourably disposed towards the point of view being communicated. Two-sided arguments are more effective with those who may be opposed. People who have more education are more influenced by messages which put two sides of an argument, while those who are less well educated are influenced more by one-sided arguments.

An example of a one-sided argument appeal is: "Two is better than too many" the slogan of a family planning campaign carried out through radio, television, posters, advertisements.

An example of a two-sided argument appeal is: A poster listing the advantages and disadvantages of different methods of family planning, leaving it up to the client to make the decision about what is best for them.

Direct or indirect

Direct appeals state a message very clearly and specify how people can respond to the message. For example: “We plan our families, we know that family planning is safe. Let the family planning centre help you”. Whereas an example of an indirect appeal around the same idea would be: “Every child a wanted child”.

Repeated or "one time" appeals

Research shows that repetition increases the amount of information that an audience remembers. Hearing messages several times helps people to remember information or ideas. Giving people information once does not necessarily mean that they will remember, understand or act on it. Priority messages need to be repeated more often.

However, after being repeated three or four times, not much additional information is remembered. This is because people tend to become bored with hearing the same message repeated in the same way too many times and after a while they ignore the message. The effects of repetition also depend on the message itself. Repetition can have a negative effect if the message is unclear or offensive. Humour also tends to loses its appeal more quickly than other types of appeals when it is repeated.

If the message is believable, strong and relevant, repetition can increase effectiveness, provided that the way the message is expressed and presented is varied to prevent audience boredom, and the interval between a repetition is increased each time the message is given. For example: once a day for three days, then once a week for three weeks, then once a month.

Definite conclusion or open conclusion

Should the message have a definite conclusion or leave the audience to make up their own mind? Drawing a conclusion may offend those who object to having the obvious pointed out to them, and may be particularly counterproductive with better educated audiences who can work it out for
themselves. Health planners and managers need to decide whether there are audiences where it is appropriate to draw conclusions.

**Steps in message development**

1. **Assess the information needs of the target audience**

   Messages must provide the audience with the information that they need if they are to succeed in changing knowledge, attitudes and behaviour. Community diagnosis and analysis should have provided an understanding of people’s information needs, but you can find out about information needs in more detail from:
   - Clinic staff and records, for example reviewing clinic records can tell you what are the most common problems, for example that people stop using contraception or do not take the whole course of treatment for tuberculosis.
   - Interviews, focus group discussions and information volunteered by clients in health facilities can, for example provide an insight into reasons for problems, such as not receiving clear information or instructions, misinformation, lack of community or health workers support to maintain behaviours.
   - Feedback from community health workers, for example a report from a CBD that men in her area resist family planning because they think it encourages promiscuity, indicates that there is a need to educate men about family planning.
   - Research reports, for example knowledge, attitudes and practice studies, reproductive health surveys, or epidemiological studies, can provide useful insights into community information needs.

2. **Develop message concepts**

   This step involves using information from community diagnosis and analysis and assessment of information needs to identify priorities and develop broad ideas for messages. Where possible, these ideas should be based on culturally acceptable alternatives to traditional or harmful behaviours and practices.

   Thinking about broad concepts consists of developing preliminary ideas for themes, slogans, words and phrases, and illustrations. For example, in Chipembere, community analysis and diagnosis showed that most couples have six or more children and a third of women have their first child before they are 17 years of age. Based on this analysis and assessment of information needs, broad message concepts could be developed with ideas for themes, illustrations and slogans:

   **Themes:**  “The need for a small family” and “The problems of early childbearing”

   **Illustrations:** A picture of a pregnant schoolgirl talking to her boyfriend at the gates of Chipembere secondary school, with the boy’s expression showing that he is telling the girl he will not accept any responsibility for the baby, could be used to illustrate the second theme

   **Slogan:** "Plan now for a better life" could be applied to either of the two themes.

3. **Pre-test the concepts**

   The next step is to pre-test the broad concepts with groups or individuals representing the intended target audience. This helps to identify which concept or concepts have the most potential for further
development. Pay special attention in pre-testing to pictures and other non-verbal materials because these can be easily misunderstood.

4. Design specific messages

The first three steps helped to decide what information is required, the general concepts we want to get across, and which of these has the greatest potential. The next step is to design more specific messages. At this stage it may be useful to refer back to questions about type of approach and appeal, and to remember that people can only remember a few messages at a time.

Think about specific messages in terms of “what”, “why”, “how”, “where” and “who”. Using the Chipembere example, messages could be considered in terms of:

| What: | The promotion of the small family norm |
| Why: | Socio-economic and health benefits |
| How: | By using modern methods of family planning |
| Where: | Services available from CBDs and health centres |
| Who: | Role models setting an example by having small families |

Examples of specific messages developed from the broad concepts for the Chipembere example might be:

**Broad concept:** Small family norm

**Specific messages:**
- Two is better than too many
- Two is enough
- Boy or girl, two is enough

**Broad concept:** Problems of early childbearing

**Specific messages:**
- Targeted at schoolgirls:
  - Be a woman before you are a mother
  - Enjoy your youth, don't spoil it

- Targeted at schoolboys:
  - Would you be more careful if it were you?

Think about designing specific messages in terms of language and timing. For effective communication and learning, IEC needs to use language and terms that are familiar to people. Care is required with choosing words, written or spoken. Even if pictures are used for less literate audiences, words are often used to explain the pictures.

Messages should be designed to be delivered when people are most likely to listen to them and be receptive. For example, a mother is more likely to be interested in messages about preventing diarrhoea when her child is ill with diarrhoea, so messages could be designed for use in clinics.
ILLUSTRATIONS

- Work with a local artist to determine how messages can best be portrayed visually
- Prepare several illustrations for each message so that the target group can decide which they prefer
- Decide on how illustrations will be placed to enhance the text

5. **Pre-test complete messages and materials with the target audience**

The purpose of pre-testing is to see whether the audience understands the message as intended. In other words, does the message work? Pre-testing is one of the most important steps in developing messages and materials. Although it takes time and adds to the cost, it prevents resources being wasted on producing final messages and materials that are ineffective or unacceptable. You can check understanding by asking the audience to tell you what they have heard and understood and what they will do.

Pre-testing should check the effectiveness of the message, in relation to:
- Attention – Does the message attract and hold the attention of the audience?
- Comprehension – Does the audience understand the ideas the message is intended to get across?
- Believability – Is the message believed?
- Recall – What does the audience remember about the message?
- Relevance – Does the audience think the message is relevant to their lives and their view of the world?
- Acceptability – Is there anything about the message which people dislike or find offensive?

Organising pre-testing involves:
- Deciding what method to use (for example focus groups or interviews) and developing instrument for pre-testing (for example checklists for focus groups or questionnaires for interviews)
- Identifying a sample from the target group and recruit the sample, explaining what you want them to do and why and how long it will take
- Testing a few messages or materials at a time, otherwise people may get confused
- Selecting a quiet place for pre-testing
- Training those who will conduct the pre-testing

Incorporate comments and suggestions for improvement into the messages and materials and if necessary pre-test the revised versions again. It may be necessary to obtain permission or approval for production of materials or media and it is useful to involve the relevant people or committee as early as possible in the process.

6. **Pre-test existing IEC material**

In assessing resources available you will have already identified if there are existing materials that could be used for IEC activities. If you intend to use or adapt existing material, it is important to pre-test it to check that the content is still relevant and effective, especially if the material was produced some time ago.

**Select communication channels and tools**

Community diagnosis and analysis should have provided information about how information is
received, shared and processed. Use this information to select the most appropriate media to reach the intended target audience.

The selection of media for communication should be based on the characteristics of the target group, the level of media technology and the effectiveness of the media in reaching the target group and facilitating behaviour change. It is particularly important that the channels or media selected are:

- Considered to be a credible source of information
- Culturally acceptable
- Appropriate to the literacy level of the audience
- Accessible to as many of the intended target audience as possible

Possible media and channels could include interpersonal communication, group discussions, radio, cassettes, films, slides, video, television, print materials such as posters and pamphlets, calendars, newspaper articles, quizzes, and radio spots. It may also be possible to utilise schools, peer educators, or non-government organisations as channels for communication in addition to health service providers. Possible mass communication channels in Zimbabwe include mobilisation of NGOs such as the Women's Action Group and YMCA and YWCA, and of the private sector, for example through the Commercial Farmers' Union.

Using a range of different media is usually most effective. If multiple media are employed, activities need to be co-ordinated to ensure maximum impact of mass media messages is achieved. Steps should also be taken to ensure that there is interpersonal reinforcement by influential groups and individuals, such as opinion leaders and health professionals. Every interpersonal encounter, radio spot and poster should recommend specific action to be taken and the messages should be consistent in all media used.

Using a range of different strategies is also effective. The example in the Box, which is about teaching a child about brushing their teeth, shows the range of different strategies that can be used.

| • Describing what could happen if teeth are not cleaned (understanding risk) |
| • Involving the child’s older siblings or friends (positive peer pressure) |
| • Saying that everyone else does it (social norms) |
| • Encouraging the child to feel good about having clean teeth (increasing self-esteem) |
| • Providing a toothbrush or cleaning stick (access to materials) |
| • Demonstrating and helping and encouraging the child to practice (skills development) |
| • Building on what the child thinks about teeth brushing (increasing knowledge) |

Interpersonal communication and mass communication are discussed in more detail in Chapter 5, and Chapter 6 provides more information about communication tools and different types of media.

**Mobilise resources**

Resources available will have been identified at the assessment stage. These resources – organisational support, community involvement, and materials – need to be mobilised and their role in IEC activities defined.

Support needs to be mobilised at all levels. High level commitment is important and the support of policy makers can be mobilised through advocacy and use of the media. As for any other audience it is important to understand the knowledge, beliefs and attitudes of policy makers in order to develop appropriate messages intended to change their behaviour.
Networking is an important component of mobilising support. When planning IEC activities and programmes, consider what alliances you will need to make to ensure co-ordinated and effective mobilisation. Alliances can be formal or informal, depending on common interests. Consider how the following could be involved:

- Political parties
- Co-operatives
- Professional groups, business organisations and unions
- Mass organisations
- Religious groups
- Non governmental organisations
- Traditional community organisations
- Research institutions
- Print and electronic media
- Youth and women's groups
- Health service structures

It is also very important to build social networks. These networks have been described as the engine of community mobilisation, and are important in convincing others in a target group to adopt new or modified behaviours. Networking has been used successfully with commercial sex workers, truck drivers and the army. Conducting a community network analysis involves finding out how the target audience interacts with its members as well as other groups in the community. It can help to draw a picture of the network of social relationships.

IEC can strengthen and use social networks by providing training and materials, working with members of particular groups to develop interpersonal outreach activities to target their network.

**Community mobilisation**

Community mobilisation is the process of motivating and bringing together people to identify problems and solutions, using their own resources or those brought in from outside. It is crucial to the success of community IEC.

Community mobilisation involves a number of tasks (see example for Family Planning IEC in Box) and depends on the following:

- The IEC or community health worker has the trust of the community and is able to assist the community to identify problems, prioritise needs, identify solutions and take decisions
- The Cupertino and involvement of formal leaders such as the District Administrator and schoolteachers
- The Cupertino and involvement of informal leaders such as traditional healers
- The recognition of traditional beliefs and values
- The acceptance of the community and of different members of the community as an equal in decision-making and the voluntary participation of as many community members as possible

Even if people reach a decision to make changes in their lives, they often find it difficult to keep up the change on their own. It is therefore important to work with people to create changes in their environment and community to support changes in health behaviours. This means that people might need:

- Help to develop skills
- Opportunities to discuss issues, ask questions, and obtain more information or clarification
- Support from family, friends and community
- Resources, for example regular access to condoms, family planning services
Facilitating community mobilisation involves:

- Thinking, with the community, about what can be done to solve problems, by discussing beliefs, attitudes and actions that affect behaviours
- Setting priorities for problems to be tackled with the target group
- Talking to the community and using participatory methods to help them identify problems and solutions
- Developing activities that are culturally sensitive
- Encouraging the participation of sub-groups including the poor and marginalised, and encouraging community leaders to see the activities as their own
- Involving people in the development of plans, implementing activities, deciding about monitoring methods and monitoring and evaluation

The essential elements of mobilisation are:

- Leadership – identifying organisations, individuals that have the greatest potential as health communicators who are leaders in the community, for example government ministries, political structures, traditional leaders, churches, trades unions, professional associations, farmers associations, women and youth groups, business clubs, prominent individuals
- Identification of social needs and goals – mobilisation must be for a purpose, it is more effective when there is a concrete community issue to address
- Resources – assessment of resources and infrastructure available for use
- Opportunities – in particular choosing the right time for mobilisation and the right settings
- Management – arranging organisational conditions and methods of operation to enable the mobilised community to achieve their objectives, including establishing effective administrative structures that are acceptable to the community
- Techniques – include research, planning, training, public relations, co-ordination, campaigns, social marketing, use of the mass media and interpersonal communication, are tools for achieving successful mobilisation

**COMMUNITY MOBILISATION FOR FAMILY PLANNING**

The following are examples of tasks which might need to be carried out when planning to mobilise a community around family planning issues:

- Identify community leaders and other influential people who can actively support family planning
- Assist community leaders in arranging and conducting group meetings on family health and family planning issues
- Liaise with other health workers in the community, for example Community Based Distributors, Village Community Workers, and arrange meetings
- Give support to family planning acceptors and those who have already accepted new health measures
- Distribute and explain printed health education materials on family health themes
- Use other existing structures where possible

**Draw up an action plan**

Drawing up an action plan should include:
* Listing all the IEC activities planned and thinking about:
  • what will be done
  • where activities will be done
  • when they will be done
  • how they will be done
  • who will do them

* Listing all the resources (people, materials, organisations) available and those you need to obtain

* Developing training plans:
  • Who will be trained, when, where, for how long and who by? Trainers? Service providers? Community organisations?
  • What are their training needs?
  • What will the initial training cover? Communication skills? Skills in use of equipment and materials? Counselling techniques? Improving knowledge? An example of what might be included in an IEC training course is included in the Box below.
  • What scope is there for follow-up training, for supervision and support to personnel after training to help them overcome problems and implement IEC activities effectively?

It may also be worthwhile considering developing guidelines for IEC that cover communication skills and use of materials, to reinforce training. But guidelines are not a substitute for training and are not the best way to develop skills. Without skills and confidence front line health workers and others are unlikely to utilise the materials provided to them.

* Preparing a schedule and time frame for carrying out planned activities

* Assigning tasks to appropriate personnel to make sure that they will be available when required

* Preparing a budget, which include line items for all activities, personnel, materials development, pre-testing and production and distribution, training, equipment, transport, monitoring, supervision and evaluation

The following Table shows the different stages in the cycle of management of IEC/health education interventions and materials.

<table>
<thead>
<tr>
<th>Cycle</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning</td>
<td>1. Identify problems and causes with other units</td>
</tr>
<tr>
<td></td>
<td>2. Identify problems that IEC/HE can tackle</td>
</tr>
<tr>
<td></td>
<td>3. Decide strategies, possible media and target audiences</td>
</tr>
<tr>
<td></td>
<td>4. Produce guidelines on use of materials</td>
</tr>
<tr>
<td></td>
<td>5. Prepare a media brief</td>
</tr>
<tr>
<td></td>
<td>6. Produce draft distribution plan</td>
</tr>
<tr>
<td>Design</td>
<td>1. Engage designer and provide brief</td>
</tr>
<tr>
<td></td>
<td>2. Decide message/slogan</td>
</tr>
<tr>
<td></td>
<td>3. Review drafts of message/slogan</td>
</tr>
<tr>
<td></td>
<td>4. Engage artist/illustrator</td>
</tr>
<tr>
<td></td>
<td>5. Pre-test materials</td>
</tr>
<tr>
<td></td>
<td>6. Summarise and review results of pre-test</td>
</tr>
</tbody>
</table>
Production
1. Finalise materials
2. Produce artwork
3. Sub-contract origination and printing
4. Finalise distribution plan

Distribution
1. Distribute materials and monitor effects

Feedback
1. Review reports and summarise results
2. Review results and summarise actions
3. Distribute and discuss results and proposed actions

Evaluation
1. Design evaluation tools
2. Conduct evaluation and distribute results

Barriers to effective implementation include:
- Competition or lack of Cupertino between departments
- Unclear definition of roles and responsibilities
- Understaffing
- Top down approach
- Discrimination
- Inadequate training
- Lack of consultation with colleagues and taking unilateral decisions
EXAMPLE OF FAMILY HEALTH COMMUNICATION TRAINING COURSE

Objectives

At the end of the course participants will be able to:

• Explain the relationships between population, family planning and socio-economic development
• Acquire knowledge and skills in family health communication
• Develop effective communication strategies for health and family planning programmes
• Develop effective tools and techniques for conducting audience research and community analysis
• Develop projects in which IEC addresses specific problems of family health

Course modules

Module 1 Population, development and family planning
Module 2 Family health/IEC country situation analysis
Module 3 Family planning
Module 4 Contraceptive methods and counselling
Module 5 Human factors in family health communication
Module 6 Family health communication and AIDS
Module 7 Theories on communication and behaviour change
Module 8 Innovations in family health communication, adolescent health communication, gender and health communication
Module 9 The changing role of the family health communicator, IEC
Module 10 Interpersonal communication skills and counselling
Module 11 Audience research
Module 12 Message development and materials production
Module 13 Advertising, public relations and social marketing
Module 14 Leadership, social mobilisation and community participation
Module 15 Field experience and community analysis
Module 16 Designing a communication strategy for health and family planning

Source: Centre for African Family Studies, Nairobi, Kenya

Monitoring and evaluation

Monitoring is about checking the progress of planned activities to ensure that they are being carried out according to plan. The purpose of monitoring is to identify weaknesses and problems in order to take timely corrective measures. It is a process that checks whether programmes and activities are effective, efficient:

Are the means chosen effective in achieving the objectives?
Is the employed methodology proving to be cost-effective: does it maximise proposed benefits and ensure that time schedules are met?
What is the extent of the programme’s impact?

Monitoring should take place continuously throughout implementation. Emphasis should be placed on recording, analysis and feedback. An ideal monitoring system should include:

• A method of data collection, with data collected about timing, inputs and outputs of activities
• A decision on the method of data analysis
Dissemination of results to decision-makers and those involved in implementation

IEC activities that might need to be monitored include:
- The effectiveness of training programmes
- Levels of participation
- Volume and quality of materials produced
- Distribution of materials
- Quality of interpersonal communication
- Work schedules
- Availability, accessibility and acceptability of messages and materials to target groups
- Effective utilisation of materials
- Ease or difficulty of use and understanding of messages and materials
- Linkages with other organisations and services

More specifically, questions which monitoring can help to answer include:
- Do the IEC activities work? Are the messages acceptable and being correctly understood and interpreted? Are the right channels and media being used to convey information?
- Have people changed their knowledge, attitudes or behaviour as a result of the IEC activities?
- How can we tell whether this change was as a result of the intervention?
- What are useful indicators?

Evaluation is about assessing whether or not objectives have been achieved. In other words, evaluation involves showing that change has taken place, that the change was the result of the IEC activities, and that the amount of effort required to produce the change was worthwhile.

There are two types of evaluation:
- Process evaluation
- Impact evaluation

Process evaluation is similar to monitoring in that it is the continual analysis during implementation of inputs, effects and impact – timeliness, accuracy, efficiency and problems. It should provide information to help managers to adjust objectives, policies, implementation strategies and activities as needed.

The purpose of impact evaluation is to find out if the activities made any difference and what changes have occurred:
- To assess whether the objectives have been met
- To determine whether or not a selected programme was completed in the minimum possible time using least-cost approaches
- To determine whether the programme components were sufficient to achieve planned objectives
- To assess impact, for example whether or not the knowledge, attitudes and behaviour of the target group have changed as a result

To be able to evaluate IEC activities, planners and managers need to decide on what changes will be measured (indicators) and how these will be measured. Indicators are ways of measuring progress or change. They are yardsticks which we use to check whether we have achieved our objectives against targets. To be able to measure change, it is necessary to have collected baseline information to start with against which to measure progress.
An indicator could be self-reported ability to discuss safer sex options with a partner or something more specifically measurable, for example:

- Percentage of people reached who can repeat minimum messages and who report changed behaviours as a result during a specific time period after the IEC intervention or interventions
- Number of trained health personnel following training carrying out increased IEC activities
- Patient satisfaction with communication with health personnel
- Reported successful dissemination of messages
- Increased use of modern contraceptives by women of childbearing age
- Increase of men using condoms in sexual contacts
- Increase in proportion of those aged 15-49 years able to name at least two acceptable methods of protection against HIV

However, it is difficult to measure behaviour change and even more difficult to identify the factors that have led to behaviour change. Health workers often have to rely on self-reported information, rather than observable changes, especially when it concerns more private behaviours, for example related to family planning and sexual behaviour, or personal hygiene.

It can be helpful to measure changes in factors which contribute to behaviour change, for example, levels of self-awareness, improvement in knowledge and skills, changes in health seeking behaviour, level of participation of the target group, as well as linkages, organisational involvement and collaboration.

Evaluation must be carried out in close collaboration with the personnel and the audience that have been doing the work and participating in the process. In addition to telling us whether the objectives were achieved, evaluation is also useful for other reasons. Lessons learned about the effectiveness of approaches and methods can be used to improve other IEC activities and future planning, by identifying problems and their causes, and identifying and evaluating alternative approaches.

Positive results can also provide an incentive to personnel and communities. For this reason, lessons learned and findings should be shared with staff and the target audience as well as incorporated into ongoing activities.

For both monitoring and evaluation, think about:

- Collecting information systematically
- Being selective, not collecting more information that you need, and only collect information that refers specifically to what you want to measure
- Ensuring that the methods are easy to use and not too time-consuming

Data collection for monitoring and evaluation can use quantitative or qualitative methods, depending on the information needed. Information that can be measured in numbers is called quantitative. Information that concerns people’s feelings or attitudes is called qualitative.

Quantitative data can be collected using methods such as structured interviews, questionnaires, surveys, service statistics, reports, project records, recent censuses, observation.

Structured interviews use the same set of questions for all interviewees, provide quantifiable data and allow for generalisation from a small sample, but can be costly, time-consuming and need trained interviewers, and analysis can be complicated. Structured group discussions are based on specific questions that you want to ask.
Using questionnaires for a survey can help to collect information using questionnaire that ask everyone the same information in the same way. People can complete these themselves if they are literate, if not they need to be asked questions by a trained interviewer. When designing a questionnaire, decide:

- what you want to find out
- who will collect the information
- from whom and how many people
- when to collect the information
- how the information will be collected
- how it will be analysed
- what will be done with the information collected and analysed

Pre-test the questionnaire with a small group of people who are similar to the people who will be interviewed, to ensure the questions are easy to understand and that people will be willing to answer them.

Using checklists is another way to keep simple records, and can be completed regularly by IEC staff, for example recording information about:

- who is attending activities
- methods used
- numbers of people reached, condoms distributed
- new activities within the community
- other interesting observations

Qualitative data can be collected using unstructured interviews, listening surveys, focus group discussions, observation and community mapping.

Unstructured interviews do not use formal questions from a structured interview schedule, but instead use an outline of topics to serve as a guide and allow for deeper probing into individual attitudes and concerns. However, they take longer, are more difficult to analyse, prone to subjectivity and require trained and experienced interviewers.

Direct observation is easier to do, but the presence of the observer may affect people’s behaviour and there is a problem with observer bias.

Community maps are simple drawings which show information about an area in a way that is easy to understand, for example the location of schools, clinics, the number of houses, the bus terminus. They can be prepared by community members and used to analyse situations and problems.

Review and replanning

Plans should also take into account the need for continuity. Communication should be an ongoing process not just a one-off campaign. One-off campaigns can be effective for raising initial awareness but need to be reinforced by ongoing IEC to ensure that behaviour change is sustained and that people are regularly reminded of key messages. To achieve changes in attitudes and behaviour takes time and repeated effort. It is therefore important to build continuity into IEC activities so that they do not end before they have had a chance to succeed. To help with this, planners and managers can:

- Review and analyse information gathered at each stage of the process
- Analyse project impact among the intended audience
• Identify significant changes in the national or local environment
• Identify missed opportunities and weaknesses
• Evaluate skills acquired by personnel as well as problems encountered
• Recycle assessment information into the design of existing or new activities
SECTION 3 COMMUNICATION CHANNELS AND TOOLS

CHAPTER 5 INTERPERSONAL AND MASS COMMUNICATION

This Chapter:
• Explains what is meant by interpersonal communication
• Outlines key skills required for effective interpersonal communication
• Describes some of the factors which may prevent effective communication
• Suggests ways in which interpersonal communication can be used in health services and programmes

Interpersonal communication is direct, face-to-face communication. It can be one-to-one or in small groups of people. In health services, interpersonal communication can be between health workers and their clients, potential clients and members of the community.

Effective interpersonal communication is about:
• Listening to what people say and finding out their views
• Inviting them to ask questions
• Being aware of their concerns
• Understanding the words and concepts that people commonly use and are familiar with
• Sharing ideas and information in a way that helps people to understand and learn more about the problem, correcting any misunderstandings about the facts
• Building on what people already know
• Using appropriate language and presenting information in a logical way
• Sticking to the most important points and not overloading the client with information
• Being specific about what people should do
• Motivating people

Interpersonal communication can be implemented through:
• Identifying trained personnel
• Training service providers
• Using advocacy and community mobilisation
• Organisational mobilisation

The most appropriate approach will depend on issues such as audience motivation, the type of information, client assessment.

Skills for effective interpersonal communication

The effective communicator needs:

Knowledge – of the facts, the information and messages to be conveyed, the channels through which it is to be provided and the audience they are trying to reach, of the local and traditional communication systems, and of local cultural beliefs

Personal qualities – which include flexibility (ability to adapt to the needs of other people), empathy (ability to share another person’s feelings), credibility, tolerance, tact, patience (ability to stay calm and not get annoyed), honesty, courtesy (politeness and consideration), approachability and sensitivity
Communicators should think about their own attitudes, beliefs and feelings; about the words they use, and how they can work in partnership with people.

Effective interpersonal communication in health programmes also requires the following skills:

**Active listening**

Good communication involves listening to what people say, as well as asking the right questions. If communication is one way and health workers or educators tell people what to do without listening to their views, they may go away without understanding what they have been told or may think the advice is irrelevant to their situation. They may feel humiliated and not want to come back to the health centre next time their child is sick or they need family planning advice, for example.

Active listening means:

- Concentrating on what the person is saying
- Respecting their viewpoint
- Checking that you have understood what the person is saying
- Being alert to non-verbal clues or body language
- Giving the person enough time to think and reply to questions

It also means NOT:

- Doing something else at the same time (for example, writing a prescription)
- Thinking about other things
- Interrupting the person when they are speaking
- Judging the person before they have had an opportunity to speak
- Monopolising the conversation

Active listening shows the person that the health worker takes seriously what they are saying, helps to avoid misunderstandings and encourages them to speak fully and frankly because they know their ideas will be listened to.

The health worker or educator gives the person their attention and makes time for them, showing that they are listening by nodding, making eye contact or looking at them, and by responding to what they say.

**Repeating and interpreting**

Repeating (using the actual words used by the person) and interpreting (using what the health provider hears, sees and knows to fully understand what a person thinks and wants) are important skills. Repeating shows that the health worker is listening and encourages a person to talk. Interpreting gives them a chance to explain and correct any wrong assumptions that may have been made. Summarising and paraphrasing helps to assure the client that the health worker has heard and understood. For example "Are you saying that.. or "So you mean that" or:

Client: "I don't know what is the matter. I just don't feel well today."
Nurse: "You are feeling sick today?"

**Reflecting feelings**

The health worker observes and then tells the client what they think they are feeling. This helps the client to feel understood, and can create empathy and defuse problems. For example "You seem
Asking questions can encourage a client to communicate. The way questions are asked is very important. Good questioning allows a real exchange of information between health worker and clients. Questions can be closed or open.

Closed questions:
- Are those that only need a "yes" or "no" answer
- Often begin with the words "Have", "Has", "Did", "Do", "Are", "Will". For example "Have you given your child ORS?"
- Are useful to find out basic information but may give the client little opportunity to say anything and they may answer yes to some questions because they think that is what the health worker wants to hear
- Limit the possible response and can be useful if the health worker wants to focus on an issue, but may mean that important information is missed

Open questions:
- Require a client to say more than "yes" or "no" by encouraging them to describe what they think or did and can be used to obtain more information without influencing the response. For example "How have you been?"
- Often begin with "What", "When", "Why" or "How". For example "What makes you think that your baby has a serious respiratory illness?"

Encouraging and probing

The health provider should encourage the client if they seem a little hesitant or uncertain, by prompting. For example "And then what happened next?". Sometimes silence can be encouraging, the health worker does not always have to say something.

Prompting and probing can be used to obtain more detailed information. For example "Tell me more about..." or "Is there anything you left out?" Questions need to be worded carefully if the subject might be considered private or sensitive.

Clarifying

If a health worker does not understand what a client is trying to say it is better to say "I am not sure I understand the point about..." or "Can you explain again?" than to guess what the person is trying to say or ignore it.

Praising

Making positive statements can help the client to feel good about themselves. For example "You took that packet of pills perfectly" or "You did the right thing to bring the baby to the clinic".
Checking understanding

The health worker should check that the person has understood what has been discussed, knows when to return if this is necessary, and ask if there is anything else that they would like to know or if they have any questions.

Supporting

Even if clients understand the message they may not have the resources to put new behaviours into practice. It is important for health workers to take time to help people to identify how they will obtain the resources they need and to give them confidence and encouragement. For example "Where will you obtain condoms?", "Do you have the ingredients to make this cough mixture at home?" or "Who will look after the children when you go for your TB treatment?"

Barriers to communication

There are many reasons why communication may not be effective. Some of the most common factors and suggested ways to overcome these barriers to communication are listed below.

Characteristics of the audience

Age - Some people may not feel comfortable communicating with someone who is older or younger than them. Action: Find out how your audience feels during community analysis and decide who can relate to clients of different ages most effectively.

Religion and culture.- Some people have negative views about family planning, for example, for religious or cultural reasons and may therefore ignore messages about the subject. Action: Use the background information collected during community research to help determine the best approach.

Gender - Some people prefer communicating about certain subjects with someone of their own sex, for example, women may feel more comfortable talking about family planning with a female health worker, whereas men may prefer to talk to a man about sexual behaviour or condoms. Action: Use information gathered from community research and ensure that female or male personnel are available for IEC activities where gender is an issue.

Language and educational level - Health workers learn about illness using technical and medical terms. These terms may not be used by clients or be understood by them. Action: Community research should have provided information about words people use to describe illness and health workers need to use these during their IEC activities.

Service providers

Knowledge - If service providers themselves are unsure or have inadequate knowledge of a subject this makes it difficult for them to communicate clearly or to answer questions. Action: Training and support to enable service providers to be familiar and up to date with the subject of IEC.

Attitudes and behaviour – Talking too much, being patronising, negative or unfriendly can affect the impact of messages, for example, if a service provider does not believe in family planning or is judgmental about the behaviour of the audience being addressed. Action: Training should address the importance of a positive and non-judgmental attitude.

Logistics
**Timing** - The timing may not be suitable. For example it may be a time when women are busy with domestic tasks or people may have other more urgent concerns and priorities. *Action:* Ask people what time of day would be most convenient for them.

**Setting** - If the setting is too noisy, cold or hot, lacks privacy or people are uncomfortable for any reason they will be less likely to listen or talk. *Action:* Choose the place for IEC activities carefully and ensure that an individual or group will be as comfortable as possible.

**Presentation**

**Messages** - Lack of clarity, ambiguity and too much or too little information are all potential communication barriers. *Action:* Make sure messages are clear and have been carefully pre-tested to check for understanding.

**Using interpersonal communication in health services**

Interpersonal communication is an influential tool for the adoption of health behaviours and continued compliance with and maintenance of such health behaviours. Interpersonal communication is the most important aspect of health education and IEC, as it enables individuals and small groups to explore issues in greater depth, which is crucial for behaviour change. Mass media can only influence knowledge and attitudes, and is best used for simple, informative messages.

In health services, interpersonal communication should establish trusting relationships between people and includes the processes of education, motivation and counselling.

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**TALKING ABOUT SEX AND RELATIONSHIPS**

Because most people are infected with HIV through unprotected sex, HIV/AIDS IEC must involve discussion about sex. This is not always easy. Talking about sex can be difficult and embarrassing because:

- Some cultures have strict rules about when, with whom, and how sex is discussed
- Men and women have different ideas about sex and what it means to them and partners find it difficult to talk to each other
- Certain activities are disapproved of and never discussed publicly but may be happening

Finding a starting point for discussing these issues is often difficult. It helps to listen to what people say, explore what they think, know, feel and value, before trying to discuss the issue.

An NGO used the following methods to stimulate community discussion about behaviour change, rather than using traditional HIV/STD education:

- Body mapping, where the participants are asked to draw their own bodies and genitals. There is usually much laughter at the beginning and this helps participants to relax and talk more openly.
- Explanations of STDs and HIV and how they are transmitted, using cloth pictures.
- Discussion about types of sexual behaviour which might be a risk for transmission and role plays depicting typical situations in the community

**Counselling**

Counselling is an important form of interpersonal communication, exchanging information to clarify
and resolve problems. Health workers need to be able to counsel clients, helping them to look at their problems, make informed decisions and identify solutions.

There is often confusion between counselling and IEC since the approaches may be similar. The main difference is the setting. IEC generally deals with a number of people at a time, focuses on preventive aspects without any emotional or psychological issues involved, whereas counselling usually deals with an individual and their specific needs and problems including emotional and psychological issues.

Counselling aims to share information about a disease and treatment and behavioural options, to promote compliance through negotiation with the client over positive treatment and behaviour changes, and to help them make informed decisions.

Counselling involves using the interpersonal skills described above. Effective sharing of information, checking for understanding and establishing achievable behavioural objectives with the client are all important counselling skills.

The following steps are a useful guide, though not every counselling session will consist of all six:

G **Greet** the client in a friendly, helpful and welcoming way, to establish rapport and make them feel at ease

A **Ask** the client about his or her needs and feelings and reassure them that their worries and concerns are normal, take a history if appropriate

T **Tell** the client all the information he or she may need, for example about procedures, services, products they may need

H **Help** the client to make an informed decision, and ensure that they are clear and happy with their decision and have no persistent doubts

E **Explain** the relevant facts related to the decision made, and summarise the discussion

R **Return** visits should be planned

It is also important to remember not to decide what the problem is before the client has finished talking.

Counselling should provide people with: enough information, relevant information, information in a way that is easy to understand and acceptable, in order to be able to make an informed decision.

Motivation is an important aspect of counselling, which can help clients to realise the benefits of adopting a particular behaviour. Motivation may depend on the health rationale, family reasons, social and national reasons – any of these factors may motivate people. Depending on the health behaviour, different groups may need to be motivated for example with family planning, it may include women, men, adolescents, defaulters and old users, clients whose reproductive goals have changed.
AIDS COUNSELLING

HIV/AIDS counselling is a confidential dialogue in which the counsellor tries to establish a safe non-threatening, non-judgmental relationship with a client so that the client can freely express their emotions, feelings and concerns.

Counselling may be needed for different groups of people: the worried well, pre-test, post-test and to provide ongoing support. The worried well need counselling which helps them to change their behaviour and lifestyles to avoid infection.

Group work

Group talks are an important way to impart information to several people at the same time. Participation is important because:

• All participants become involved in the discussion
• Participants share common ideas and concerns and come up with solutions
• Participants share feelings and reveal social attitudes
• Participants can be influenced by others in the group to change their attitudes and behaviour
• Misconceptions can be corrected

Working with groups aims to:

• Build on knowledge – to review what people know and believe
• Think about risk
• Explore attitudes – to reflect on their lives
• Practise new skills – to learn about new skills for healthy behaviours
• Solve problems and make decisions – to define problems and barriers to change and to find realistic ways to overcome them

To be able to do this it is important to know the audience and their information needs, perhaps through reviewing research, clinic reports and records or observing common questions asked by clients. During a group discussion you can assess information needs by asking questions, observing participants’ facial expressions and body language, for example whether they look puzzled or uncomfortable.

Group talks need to be held in a quiet place, with small groups, at a convenient time for the participants, and the talk should not be too long or too short. Prepare objectives and a list of questions to stimulate discussion, ensuring that the main points you want to get across are covered, also consider what visual aids might help to illustrate the discussion and the points.

Those conducting a group talk need to:

• Introduce the topic for the talk
• Encourage a friendly and informal atmosphere
• Guide and stimulate the discussion by asking open-ended questions
• Encourage people to ask questions
• Give clear and correct answers to questions

Build on knowledge

Activities to help people to identify the gaps in their HIV/AIDS knowledge and information could include:

1. Finding the gaps – for example, ask people to identify all the different ways they think HIV is
spread, write the suggestions down on a chalkboard, with the words True or False next to them, then ask people to decide whether to place a tick next to each suggestion, and use this information as a basis for discussion

2. Checking beliefs – for example, to help people to consider their beliefs about HIV/AIDS, give everyone in the group a statement written on a card which reflects common beliefs, ask each person to discuss the statement on their card with another group member, then to read out the statement stating what they think about it; this can be done with non-readers without using cards

Thinking about risk

Activities to help people to think about risk could include:

1. Ask people to think about any occasion when they might have taken a risk and to consider what factors influenced their decision to take a risk, what their feelings were at the time, what was the result of taking the risk, how they view risk taking in others, then ask them to discuss this with another participant and then encourage the whole group to discuss this

2. Most risk/least risk – give each participant three small cards and ask them to write down three sexual activities, one on each card. Write Most risk, Least risk and Don’t know on three larger cards. Shuffle the participants cards and give them to pairs of participants and ask them to place them near the large card they think is appropriate. Choices made should be discussed in the larger group.

Exploring attitudes and feelings

Activities to explore attitudes and feelings could include:

1. Write three large cards, with Agree, Disagree and Not sure on them, put in different parts of the room, read out a series of statements and ask people to move to the card which represents their view after each statement. Ask them to explain why they have chosen to stand there and to discuss it with others standing in different places. Invite people to say how they feel about listening to other people’s opinions without discussing them, about explaining their views to someone else, and any changes in their opinions after listening to other people’s point of view.

Practising new skills

Activities for helping people to practise new skills could include:

1. For example, to introduce the use of condoms, give each participant a condom, ask them to check it is not past its expiry date, to open the packet and take the condom out, stretch it and play with it. Ask the group in pairs to discuss how they feel about handling the condom. Back in the main group invite people to make comments. Demonstrate condom use using a carrot or a wooden model of a penis, then ask people to try doing it themselves. Encourage discussion about what was difficult and what might help them to use condoms with a partner.

2. Role play is another useful method for developing and practising skills. During a role play two or more participants pretend they are in a certain situation and act out how people might behave in that situation. Use the following three steps: Describe the situation or problem and ask two or three people to volunteer to act out the situation, for 5-10 minutes. As the participants to discuss what happened during the role play, and to make suggestions for overcoming the problem. Role play can be a useful method for women to practice assertiveness and negotiation skills for practising safer sex with their partners, especially if the latter are likely to be reluctant to use condoms.
Solving problems and making decisions

Activities for helping people to solve problems and make decisions could include:

1. Picture codes, which are poster-sized illustrations without words showing a situation about which people may have strong feelings. Ask the group what is happening in the picture, whether this happens in real life, why it is happening, how the picture makes them feel, what are the root causes, and what can be done about the situation. At the end of the discussion summarise what has been said.

2. Another useful method is the open-ended story, where the facilitator tells the beginning of a story but stops at the point where decisions need to be made. The story should present a real life situation and raise issues that people can understand easily. When the story stops ask the group what might happen next, what choices the characters have and what they might do. Encourage them to discuss the problem and to suggest solutions.

3. Another activity is identifying barriers to change. Ask the group to identify a problem and write it in the middle of a flip chart, and the invite the group to think of and name possible causes of the problem and to identify the ones where they feel change is possible. Encourage discussion about how they could help to do this.

4. Using drama can raise awareness and encourage debate about issues affecting the community. Drama usually involves several people who tell a story through acting out different roles and situations. Either professional actors or members of the community can do this, deciding on the theme, doing preparatory research, perhaps through carrying out a listening survey so that they can plan the storyline based on real life concerns and language, and writing and rehearsing the story. If using drama you need with the group to decide on the aims of the drama and what it hopes to achieve, the key messages, the story and how it will be presented, work out the characters and the dialogue, and ways to highlight certain issues, for example through songs or catchphrases, mime or puppets. It is important to get feedback from the audience and to allow time for discussion of the drama.

Drama is a good method because it is enjoyable, combining education with entertainment. It can change attitudes and raise awareness by engaging people’s attention and emotions, reflect local issues and people’s usual behaviour and attitudes as well as emphasising strategies for change, respond to current problems and to what people are saying and thinking about an issue. It is also useful for openly addressing difficult issues.

Drama can be used, for example with HIV and AIDS to:

- State a problem, e.g. isolation of people with AIDS
- Expose the root causes of a problem, e.g. why young people do not know about sex
- Show how to reach possible solutions, e.g. setting up a local home-based care project
- Show the benefits of solving problems, e.g. the benefits of making a will for wives and children

But drama can fail or do harm if:

- The message is inappropriate, outdated or blames people
- The language offends the audience
- The message fails to reflect the reality of people’s lives
- It tries to cover too many complicated issues
- The audience is not given a chance to respond
• Too much emphasis is put on entertainment so the message is lost
• The same drama is performed too often in the same place without changing the story

Handling difficult situations in groups

When people do not respond to questions - Possible solutions: Assess the situation. Are participants nervous, shy or lacking confidence? Did they hear and understand the question? Repeat and rephrase the question. Give the group enough time to think and respond.

When one group member dominates the discussion - Possible solutions: State that everyone’s comments are important and that others should also participate. Encourage others to participate by asking them direct questions. Or you could ask what others in the group think.

The prepared information is not appropriate for the group - Possible solutions: If there is no interest in the topic, ask the group what they would like to discuss. If the topic is already well understood, ask them what questions they have.

Two or three participants talk to each other and not with the group - Possible solutions: Ask the participants if they would like to share their discussion with the group.

Mass communication

Mass media campaigns can reach large numbers of people simultaneously, and can create common awareness and common recognition of problems, and stimulate discussion of subjects. Mass media campaigns have the potential to provide large groups of the population with clear and consistent messages, even on subjects that are personal, and these messages can create change in knowledge and attitudes that might contribute to changes in norms, behavioural intentions and behaviours in certain situations. However, mass media campaigns can be costly and tend mainly to reach urban populations.

Social marketing

Social marketing seeks to increase the acceptability of a social idea or practice in a target group. It uses the concepts of market segmentation, consumer research, communication, facilitation, incentives and exchange theory to maximise target group response. The attitudes of consumers are critical, and the process is one of marketing rather than selling, with a focus on “exchange”.

All marketing programmes aim to satisfy consumer needs by generating demand, enabling people to try things out and to decide whether they want to adopt and innovation.

Marketing involves the determination of the best mix of the following four marketing variables:
• Product
• Price
• Promotion
• Place

These are sometimes called the four ‘Ps’. Each are inter-related. For example, the pattern of distribution, or place, is affected by the decisions on price.

Product
Product refers to what is being offered to consumers. The issues which need to be considered in relation to product are: quality control, packaging, logo and product message. Are the characteristics acceptable to users? Is the packaging satisfactory? Packaging must attract, arrest, interest, impart information and encourage purchase.

Price

Price refers to what is exchanged for the product. Pricing decisions and strategies require establishing appropriate prices and careful monitoring of competitive marketplace. Price is not just the cost of the product, but also the time, distance and other costs involved. Do users consider the product to be good value for money? What are the most effective marketing channels?

Promotion

The essence of promotion is communication. This covers product promotion, service promotion, public relations, point of purchase, consumer education, consumer advertising. What are the most appropriate advertising media?

Place

Deciding how goods get to the client, how quickly and in what condition involves place and distribution strategy. You need to decide the number of outlets where products will be available.

Social marketing may include: introduction of a new product (for example, condoms or contraceptives), modification of existing ones (for example iodised salt), restricted consumption of others (for example, infant formula, cigarettes), or it may be exclusively educational.

There are some special issues to take into consideration when designing a social marketing plan:

Advocacy – it is essential to ensure the co-operation of community organisations whose support can make the difference between success and failure
Consensus building – it is important to have consensus about the messages that will be directed at the target audience
Collaboration with the private sector – when products are involved it may be necessary to involve the private sector in planning, for example distribution of condoms, and overall strategies should be designed to make the product more widely available
Collaboration with related sectors – at national level, collaboration with policy makers is essential, at middle level with management and training, and at local level with community participation
CHAPTER 6 COMMUNICATION TOOLS

There are three main types of tools or media:

- Traditional media
- Small or print media
- Mass media

The purpose of communication tools and media is to:

- Improve the understanding of the target group
- Illustrate action and the consequences
- Show comparison between situations
- Remind people about skills they have been shown by service providers
- Provide a means of transmitting consistent messages
- Reinforce messages presented verbally
- Serve as a basis for discussion

**Traditional media**

Traditional media are ways in which communities have always shared and passed on information often from one generation to the next and usually through the spoken word or visual art. Media such as storytelling, drama, fables, songs, poems and proverbs, town criers, special festive days, concerts, puppet shows and other visual arts such as paintings, carvings and pottery figures could all be considered and are all popular and familiar ways of communicating ideas.

The most important and popular characteristic of traditional media is its entertainment value which creates a more congenial atmosphere for effective learning and possible action. It starts from where people are and what they know and can communicate messages in a way that is acceptable and understandable to them.

Traditional media are particularly useful for addressing issues affecting people’s day to day lives, such as marriage, religion, health and disease, family life, power and authority, conflicts and communal living.

Look out for traditional and popular media in your district and see if they can be mobilised for IEC interventions. Identify those involved, brief them about the planned IEC activities, and work with them to put the media together.

**Printed and small media**

These include posters, billboards, leaflets, booklets, comics, flannelgraphs, slides, photographs, bulletin boards, banners, displays, fairs and exhibitions. Materials are commonly produced centrally and distributed, but where possible should be produced at provincial or district level so that they respond more specifically to the needs and context of the area. Target groups, such as women, schoolchildren and young people could be encouraged to develop and produce their own materials or at least to be involved in developing concepts and illustrations. Drawings on the walls of popular buildings, stores and meeting places can also be effective.
**Mass media**

The mass media is made up of channels such as radio, TV, video, films, and newspapers. Radio is one of the most popular and widely accessible communication media in Zimbabwe. Television is also popular but may not be accessible to all population groups.

Mass media can reach many people quickly and at the same time. Reaching everyone in a district, for example, in a short time is not possible using interpersonal face-to-face communication. Mass media are generally credible sources of information, can provide continuing reminders and reinforcement of messages to encourage maintenance of behaviour change, and can be useful for raising awareness and bringing issues and new ideas to people’s attention.

Mass media can also be used to build positive public opinion for behaviour change by increasing knowledge or providing a forum for debate or creating debate, and to mobilise people.

Mass media does not have to be complex or large scale. At the district level there may be resources available for mass media activities. For example, local radio stations can be used for IEC activities, through interviews, spots, announcements, and district newspapers can also be utilised to promote issues and ideas and encourage debate. Individuals who own television and radio sets are often proud to share these with other members of the community. Or community facilities or cinemas can sometimes be used to screen films and videos.

Some types of tools and media are more useful for some target groups than others. For example, TV, radio, music and videos, comics and games may be more effective for young people than newspaper articles or leaflets. Similarly for rural women it may be more appropriate to use radio, video or traditional media than leaflets or billboards. Over-emphasis on printed materials and media such as radio and television should be avoided as these will not reach rural or less literate audiences.

Different materials and media are also useful at different stages of the behaviour change process. For example, radio and leaflets maybe useful to raise awareness and increase knowledge, but role play may be more appropriate for developing assertiveness skills.

The Box below describes the advantages and disadvantages of different types of media.
## Types of Media

<table>
<thead>
<tr>
<th>Media</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pamphlets and flyers</td>
<td>Flexibility</td>
<td>Poor reproduction quality</td>
</tr>
<tr>
<td></td>
<td>Broad acceptance</td>
<td>Small ‘pass along’ audience</td>
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<tr>
<td></td>
<td>High believability</td>
<td>Short lifespan</td>
</tr>
<tr>
<td></td>
<td>Good local coverage</td>
<td></td>
</tr>
<tr>
<td>Television</td>
<td>Dynamic, combines sight, sound, motion</td>
<td>High cost</td>
</tr>
<tr>
<td></td>
<td>High attention and interest</td>
<td>Fleeting exposure</td>
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<tr>
<td></td>
<td></td>
<td>Less audience selectivity</td>
</tr>
<tr>
<td>Billboards and posters</td>
<td>High repeat exposure</td>
<td>No audience selectivity</td>
</tr>
<tr>
<td></td>
<td>Low cost</td>
<td>Static</td>
</tr>
<tr>
<td></td>
<td>Flexibility</td>
<td>Short lifespan</td>
</tr>
<tr>
<td>Drama</td>
<td>Dynamic, entertaining</td>
<td>Entertainment value overshadows message</td>
</tr>
<tr>
<td></td>
<td>Interpersonal effect</td>
<td>Requires skilled actors</td>
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<tr>
<td></td>
<td>Audience participation</td>
<td></td>
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<tr>
<td></td>
<td>and dialogue</td>
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<tr>
<td></td>
<td>Flexible and mobile</td>
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<tr>
<td>Radio</td>
<td>Mass use</td>
<td>Low attention</td>
</tr>
<tr>
<td></td>
<td>High coverage</td>
<td>Short term exposure</td>
</tr>
<tr>
<td></td>
<td>Low cost</td>
<td></td>
</tr>
<tr>
<td>Workshops</td>
<td>Interpersonal</td>
<td></td>
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<tr>
<td></td>
<td>Exchange of ideas</td>
<td></td>
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<tr>
<td>Caps, T-shirts</td>
<td>Messages attractively presented</td>
<td>Sometimes message cannot be read</td>
</tr>
<tr>
<td></td>
<td>Appealing</td>
<td>Short term exposure</td>
</tr>
</tbody>
</table>

### Use and Care of Materials and Equipment

- Keep all audio-visual equipment and other materials clean and protected from dust, direct sunlight and moisture.
- Read instructions carefully
- Ensure equipment and materials are properly maintained, checked and repaired
- Display and ensure users understand instructions for use

### Posters

Posters cannot give much information and should present one easily understood message. Keep the message short and simple, ensure the message fits the picture, emphasise positive messages, use clear line drawings and avoid distracting background details. Use words only if the target audience is literate, keep the print size bold and large, ensure that drawings are recognisable and familiar to the target group. Avoid symbols that cannot be easily understood or close up illustrations that may be difficult to understand.
• Keep stored flat or rolled up
• Display out of direct sunlight, wind and rain
• Update and change regularly
• Display in a clear space at a site where the poster will attract attention, and at eye level

Wall charts

Wall charts contain more information than posters and are usually displayed for referral over a longer period of time.

Videos

Videos are often used in IEC programmes. They are useful especially when they show a real life situation relevant to the target audience. A good video should inform and entertain. Videos should be used as a tool for teaching but not as a substitute for interaction with the group.

Pamphlets, leaflets and booklets

• Store out of direct sunlight, damp and dust
• Display in a place where people can see and pick them up easily
• When using hold so that the audience can see them

Flannelgraphs

Flannelgraphs are boards covered with cloth and cloth pictures are attached to the board. These images can be put in different positions on the board and moved around to represent changing situations and events.

• Lean the board back slightly when using, avoid windy locations
• Stand beside the board not in front of it
• Keep away from damp as this causes problems with sticking

Audio-visual equipment

• Keep dry, free from dust
• Run head cleaner for tape player regularly to keep the tape head clean
• Check batteries
• If using a slide projector, check the room can be darkened effectively, test presentation, ensure slides are the right way up, don’t touch with fingers, ensure that the projector is in a stable place
• When using OHPs face the audience, stand to one side, keep sheets of paper between transparencies to avoid smudging and smearing, clean the glass screen after use with methylated spirit, replace the bulb when necessary
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About understanding: ideas and observations on cross-cultural communication. Fuglesang A, 1982, Dag Hammarskjeld Foundation. *Communication methodology, cultural beliefs, picture interpretation, language use*


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2. JOURNAL ARTICLES


3. NEWSLETTERS

AIDS Action, AHRTAG, issue 32, March-May 1996 on monitoring and evaluation

AIDS Captions,

AIDS/STD Health Promotion Exchange, Royal Tropical Institute

Child Health Dialogue, AHRTAG

Development Communication Report, Clearinghouse on Development Communication

Learning for health, Education Resource Group.

PLA Notes: Notes on participatory learning and action, IIED.
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List of free materials in reproductive health. INTRAH.

Using flannelgraphs to communicate ideas in family planning, STD and AIDS. Available from TALC, £19.50.


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Jakarta Declaration. 1997, WHO

Health Promotion Glossary. 1998, WHO
6. SOURCES OF INFORMATION

Academy for Educational Development
1255 23rd Street, NW, Suite 400
Washington DC 20037
USA
Tel: 1 202 884 8822
Fax: 1 202 884 8701

Advocates for Youth (formerly Center for Population Options)
1025 Vermont Avenue, NW, Suite 200
Washington DC 20005
USA
Tel: 1 202 347 5700
Fax: 1 202 347 2263
e-mail: info@advocatesforyouth.org

AHRTAG
Farringdon Point
29-35 Farringdon Road
London EC1M 3JB
UK
Tel: 44 171 242 0606
Fax: 44 171 242 0041
e-mail ahrtag@geo2.geonet.de

Beyond Awareness Consortium
PO Box 408
Auckland Park 2006
South Africa

CDC National AIDS Clearinghouse
PO Box 6003
Rockville, MD 20850
USA
Tel: 1 301 251 5023
Fax: 1 301 738 6616
Center for Communications Programs
Johns Hopkins University
111 Market Place
Suite 310
Baltimore
Maryland 21202
USA
Tel: 1 410 659 6300
Fax: 1 410 659 6266
e-mail: webadmin@jhuccp.org

Center for International Health and Development Communication
Annenberg School for Communication
University of Pennsylvania
3620 Walnut Street
Philadelphia
PA 19104-6220
USA

Child-to-Child Trust
Institute of Education
20 Bedford Way
London WC1H 0AL
UK

Clearinghouse on Development Communication
1815 Fort Myer Drive, Arlington
VA 22209
USA

Commonwealth Youth Programme
Commonwealth Secretariat
Marlborough House, Pall Mall
London SW1Y 5HX
UK

Communications Division
Centre for African Family Studies
Pamstech House
Woodvale Grove
Westlands
PO Box 60054
Nairobi
Kenya
Tel: 254 2 448618-20
Fax: 254 2 448621
e-mail: courses@cafs.org
Community Education Development Centre
Lyng Hall
Blackberry Lane
Coventry CV2 3JS
UK

Cornell University, Division of Nutritional Sciences
Ithaca
NY 14853
USA

Education Resource Group
Liverpool School of Tropical Medicine
Pembroke Place
Liverpool, L3 5QA
Tel: 44 151 708 9393
Fax: 44 151 707 1702

The Evaluation Project
Carolina Population Center
University of North Carolina at Chapel Hill
CB#8120, 304 University Square East, Chapel Hill
NC 27516-3997
USA

Family Care International
588 Broadway, Suite 503
New York, NY 10012
USA

Family Planning Association
2-12 Pentonville Road
London N1
UK

Health Education Unit
Ministry of Health and Child Welfare
P O Box CY 1122
Causeway
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Tel: 263 4 730011
Fax: 263 4 729154

Health Education Authority
Hamilton House
Mabledon Place
London WC1H 9TX
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Hesperian Foundation
Box 1692
Palo Alto
CA 94302
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Fax:  1 415 325 9044

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C/o ACFOA, Private Bag 3
Deakin ACT 2600
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IDS
University of Sussex
Falmer
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IIED
3 Endsleigh Street
London WC1H 0DD
UK

Intermediate Technology Publications
103-105 Southampton Row
London WC1 4HH
UK

International Child Health Unit
University Hospital
S-75185 Uppsala
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International Union for Health Promotion and Education
2 rue Auguste Comte
92700 Vanves
France
Tel:  33 1 4645 0059
Fax:  33 1 4645 0045

International Water and Sanitation Resource Centre (IRC)
P O Box 93190
2509 AD The Hague
The Netherlands
Tel:  31 70 331 4133
Fax:  31 70 381 4034
INTRAH
University of North Carolina
School of Medicine
208 N Columbia Street
CB 8100, Chapel Hill, NC 27514
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IPPF
P O Box 759
Inner Circle
Regent’s Park
London NW1 4LQ
UK
Tel:  44 171 486 0741
Fax:  44 171 487 7950

KIT/Royal Tropical Institute
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1092 AD Amsterdam
The Netherlands
Tel:  31 20 5688 288
Fax:  31 20 6654 423
e-mail: ibd@kit.nl

PATH
Suite 700, 1900 M St, NW
Washington DC 20036
USA

Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
USA

Population Services International
1120 19th St, NW
Suite 600
Washington DC 20036
USA

Praeger Publishers
88 Post Road West
Westport
CT 06881
USA
Private Agencies Collaborating Together (PACT)
777 UN Plaza
New York, NY 10017
USA
Tel:  1 212 697 6222
Fax:  1 212 692 9748

Redd Barna
Regional Office Africa
GPO 12018
Kampala
Uganda

Regional Clearinghouse on Population Education and Communication
UNESCO Principal Office for Asia and the Pacific
PO Box 967
Prakanong Post Office
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Thailand

Save the Children Fund UK
17 Grove Lane
Camberwell
London SE5 8RD
UK

Southern African AIDS Information Dissemination Service (SafAIDS)
17 Beveridge Road, Po Box A509
Avondale, Harare
Zimbabwe
Tel:  263 4 336193
Fax:  263 4 336195
e-mail: info@safaids.org.zw

STD Foundation
PO Box 9074
3506 GB Utrecht
The Netherlands
Tel:  31 30 628 234
Fax:  31 30 611 457

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Fax:  44 1727 846 852
E-mail: talcuk@btinternet.com
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Fax: 41 22 326 7336
e-mail: unaids@unaids.org

UNFPA
200 East 42nd Street
New York, NY 10017
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Tel: 1 212 297 5211
Fax: 1 212 297 4915

UNICEF
3 UN Plaza
New York, NY 10017
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Fax: 1 212 326 7336

World Health Organisation, Health Promotion Division
1211 Geneva 27
Switzerland
Tel: 41 22 791 2111

World Health Organisation, Regional office for Europe
8 Scherfigseg
DK 2100 Copenhagen 0
Denmark

World Neighbors
4127 NW, 122 Street
Oklahoma City
OK 73112
USA

Zimbabwe National Family Planning Council
P O Box ST 220
Southerton, Harare
Zimbabwe
Tel: 263 4 620280
Fax: 263 4 668678
e-mail: znfpc@harare.iafrica.com

7. ELECTRONIC RESOURCES

SatelLife
http://www.healthnet.org
Services offered include e-mail, electronic conferences, electronic publications, database access (including databases such as MEDLINE)
African Index Medicus
http://www.who.ch/pll/hlt/
Bibliographic database compiled from national databases of materials published in African countries on health, merged with records from MEDLINE, POPLINE and WHO databases

MEDLINE

POPLINE
Maintained by the Population Information Program at Johns Hopkins University, includes references and abstracts, available on CD-ROM
http://www.charm.net/~ccp/popinfrr1.html